

## **2009 Kentucky Statewide Comprehensive Plan**

### **CONTRIBUTERS TO THE 2009 COMPREHENSIVE PLAN**

The Ryan White Part B Program  
The Kentucky HIV Prevention and Surveillance Programs  
The Kentucky HIV/AIDS Planning and Advisory Council (KHPAC)  
The Kentucky Communicable Disease Branch  
The Kentucky Department of Medicaid Services  
The Kentucky Department of Education  
The Kentucky Department of Corrections  
The Kentucky HIV/AIDS Prevention Program  
The Kentucky HIV/AIDS Surveillance Program

### **CONTRIBUTING DOCUMENTS TO THE 2008 COMPREHENSIVE PLAN**

#### **2008 Kentucky Statewide Coordinated Statement of Need (SCSN)**

2008 HIV Prevention Plan  
Southern States Manifesto: Update 2008  
2007 Kentucky HIV Prevention & Care Needs Assessment  
Kentucky Department of Education HIV Project Narrative  
2007 Kentucky African American Needs Assessment  
2005 Kentucky Comprehensive Plan

## **2009 Kentucky Statewide Comprehensive Plan**

### **INTRODUCTION**

The U.S. Department for Health and Human Services (DHHS), Health Resources and Services Administration (HRSA) mandates that each Ryan White Part B grantee program develop and implement a Comprehensive Plan designed as a guiding document for programmatic decisions and activities. Each state has a unique Comprehensive Plan to respond to and address determined service needs and gaps.

The Comprehensive Plan is a dynamic document that includes annual updates and periodic modifications as jurisdictional needs change and as other programmatic adjustments are required.

In Kentucky, the process to develop the 2008 Comprehensive Plan utilized information garnered from stakeholders representing community based organizations, all Ryan White grantees, the Kentucky Department of Corrections, the Department of Medicaid Services, the Kentucky Department of Education, the community planning group, and other organizations with related interests. The content of the current plan includes and builds upon several structured processes such as Kentucky Statewide Coordinated Statement of Need (SCSN), statewide needs assessments, HIV Community advisory processes, comments from the HIV Provider community, anecdotal evidence, and epidemiological data.

### **EXECUTIVE SUMMARY**

The Comprehensive Plan addresses the barriers to care needs and gaps in services of Kentucky's Part B program. Several key needs assessments, including the 2007 Client Needs Assessment, the 2008 Statewide Coordinated Statement of Need, 2007 Kentucky African American Needs Assessment and the 2008 Prevention Plan were used as guiding documents to prepare the 2009 Comprehensive Plan. Representatives from all Ryan White Programs, including Part B, C, D, and F were involved in one or more of these processes.

The Comprehensive Plan is a roadmap to guide Kentucky's Part B program with measurable goals, objectives and effective strategies to address the barriers, needs and gaps that have been identified. The priority challenges identified for the Comprehensive Plan are broken down into the following categories:

1. HIV Care Coordination/Medical Case Management
  - Develop an HIV initiative for the correctional system, including a Discharge Planning program
  - Enhance client transportation for medical and case manager appointments
  - Provide education and training for Part B case managers regarding Medical Case Management
  - Develop strategies to better address mental health and substance abuse issues with Part B clients

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2. Clinical Care
  - Improve quality management issues among Kentucky Part C clinics
  - Increase resources and training of clinical care providers to manage co-morbidities
  - Increase collaboration between clinical care providers and HIV prevention specialists
3. Collaborations with other entities
  - Data sharing between the Part B program and Medicaid/Medicare
  - Increase internal collaborations between the HIV, TB, Immunization, and STD branches
4. Oral/Dental Health
  - Provide training and education on HIV/AIDS to private dentists in the state
  - Increase collaborations with the Part F program to provide HIV oral health trainings to the Part C clinical care providers
5. Disenfranchised Group
  - Provide cultural competency training statewide
  - Reduce stigma within African American churches
  - Improve linkages and retention in care for homeless HIV+ individuals, Hispanic individuals, and African American individuals
  - Provide education on HIV 101 to homeless shelters, Hispanic agencies, and other minority community based organizations
6. HIV Prevention
  - Educate and train members of various health disciplines as mandated by Kentucky statute
  - Develop and distribute press releases highlighting prevention activities
  - Partner with African-American churches and educational entities to educate, address, and foster service delivery regarding HIV

The initiatives in this plan will expand and enhance existing HIV services across the state and provide measurements for improvement.

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**Section I: WHERE ARE WE NOW**

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**1. Description of the Kentucky Part B Program**

The Kentucky Ryan White Part B program facilitates the provision of quality care and services to HIV infected individuals in a timely and consistent manner across a continuum of care. The Part B program is centrally administered and comprised of the Kentucky HIV/AIDS Care Coordination Program (KHCCP), the Kentucky AIDS Drug Assistance Program, the Kentucky Health Insurance Continuation Program (KHICP), and grant administration. Case management is provided at six regional sites through contracts with 2 local health departments, (Cumberland Valley District Health Department, and Northern Kentucky Independent District Health Department) and four (4) Community Based Organizations (CBOs) (Bluegrass Care Clinic, Heartland Cares, Matthew 25, and Volunteers of America, Louisville- VOA). These regional sites allow for statewide coverage and local access to core and supportive services.

See Illustration 1 (**Direct Services Components**)

**2. Epidemiological Profile**

Epidemiological Profile of HIV/AIDS in Kentucky

The Surveillance Program of the HIV/AIDS Branch, Kentucky Department for Public Health provides an overview of data on HIV and AIDS for the state of Kentucky. The Surveillance Program collected data on individuals diagnosed with AIDS since 1982. Between 1989 and July 2004, HIV cases were reported by code. In July 2004, name-based HIV reporting legislation was passed in Kentucky. HIV cases reported during the code-based period are currently under evaluation for completeness and accuracy. Therefore at this time, HIV data is only available on cases diagnosed and reported since 2005, the first full year of name-based HIV reporting. No estimates of the number of persons living with HIV in Kentucky are available at this time. The Centers for Disease Control and Prevention (CDC) will not release HIV estimates for Kentucky until four full years after name-based reporting was implemented. The majority of this report will focus on trends in AIDS cases; information at the end of the profile is dedicated to more recent data on HIV diagnoses.

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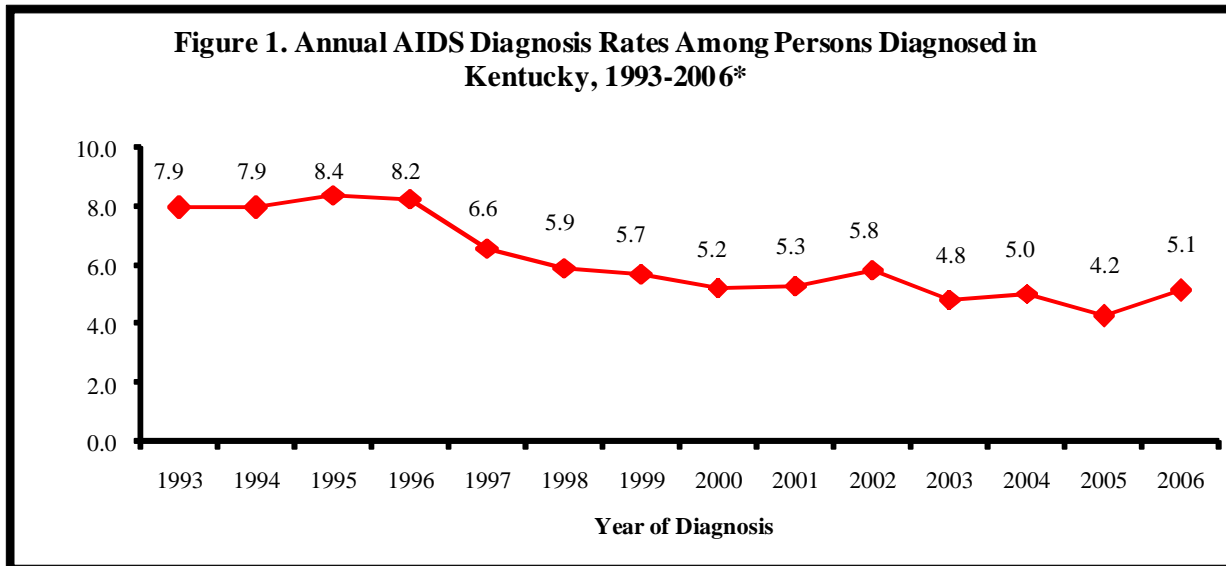
### AIDS Data

Nationally, Kentucky ranked 31<sup>st</sup> among the states for the number of reported AIDS cases, with 207 AIDS cases reported in 2006 according to the CDC. Kentucky comprised less than one percent of AIDS cases reported in the United States in 2006. Among AIDS cases reported in the metropolitan statistical areas (MSA) in the United States, 97 were reported in the Louisville, Kentucky MSA in 2006, with a rate of 7.9 per 100,000 in the population.

### **Current Local and state epidemic**

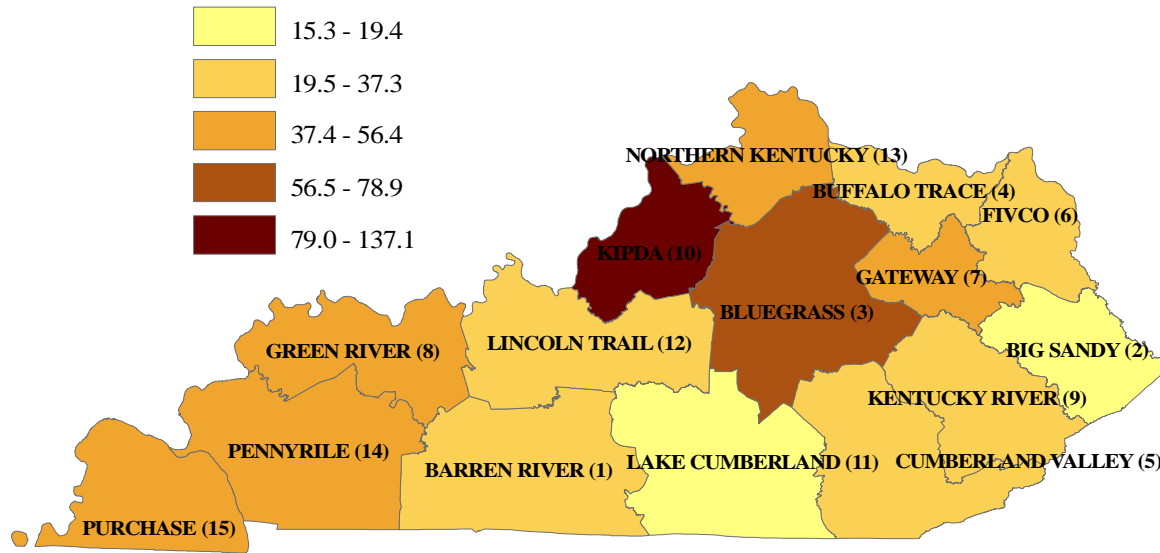
As of June 30, 2008, there have been a total of 4,890 AIDS cases reported in Kentucky to the Department for Public Health's HIV/AIDS Surveillance Program since 1982. Of these reported cases, 2,915 are still presumed to be living. In 2007, there were 237 new AIDS cases diagnosed. The annual AIDS diagnosis rate among persons in Kentucky shows a trend by year of diagnosis (Figure 1). The annual AIDS diagnosis rate has remained fairly steady from 2000 to 2006, with slight fluctuations in 2002 and 2005.

\*Data are current as of June 30, 2008. The data for 2007 and 2008 are considered provisional due to reporting delays and are not presented in trend analysis.



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**Kentucky Living AIDS Rate by ADD, 2007**



\*Figure 2. Living AIDS Rates by Area Development District (ADD) of Diagnosis in Kentucky, 2007.

The rate of living AIDS cases is highest in the KIPDA area development district (ADD), which includes the city of Louisville. The rate of living AIDS cases is second highest in the Bluegrass ADD, which includes the city of Lexington. The rate of living AIDS cases is lowest in eastern Kentucky.

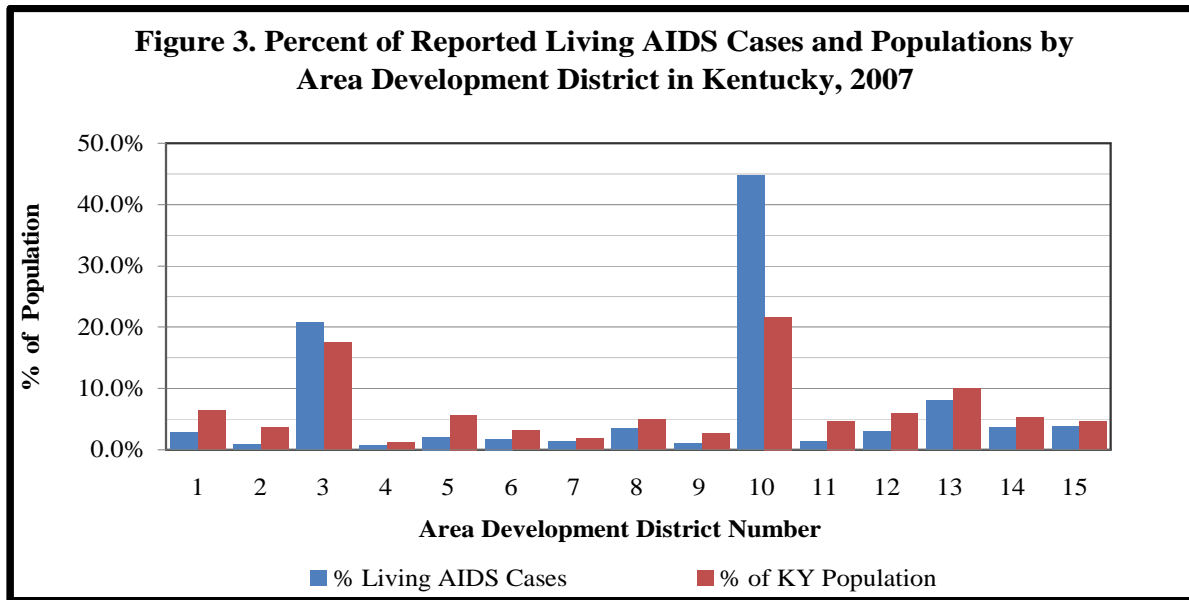
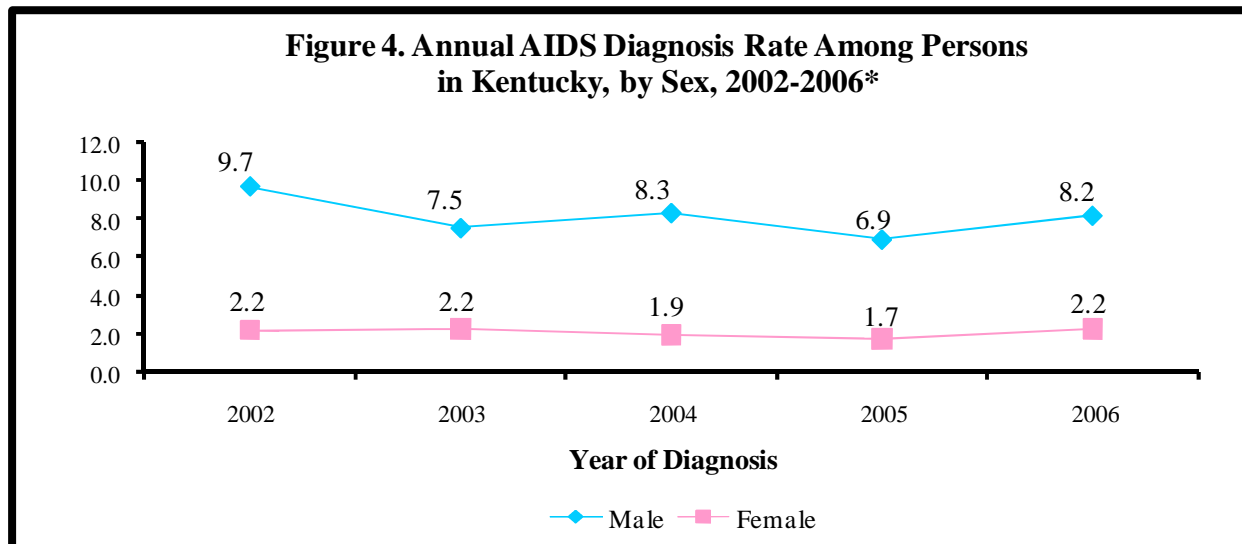
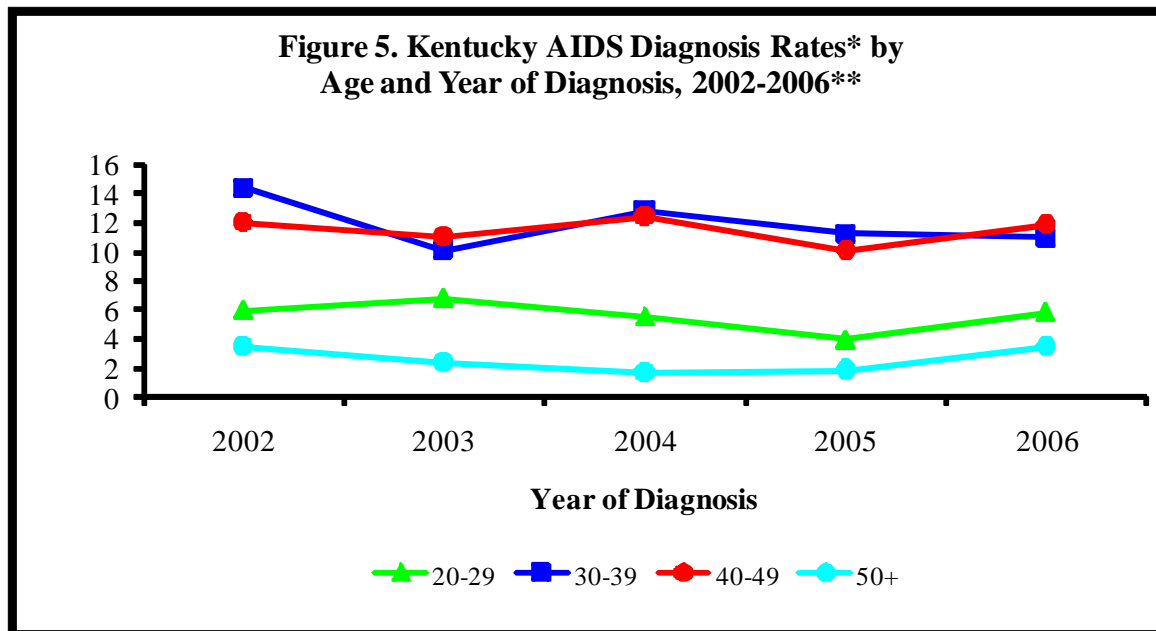


Figure 3 illustrates the disproportionate impact of AIDS on the Bluegrass ADD (3) and the KIPDA ADD (10), compared to the percent of people in the population. Although the KIPDA ADD comprises only 22% of Kentucky's residents, this area represents 45% of living AIDS cases diagnosed in Kentucky. The two ADDs with the disproportionate impact represent the largest population centers in the state.



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\*Data for 2007 and 2008 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays. Males represent the majority (84%) of total AIDS cases reported in Kentucky through June 30, 2008. On average from 2002 to 2006, the AIDS diagnosis rate among males has been approximately four times higher than for females (Figure 5). The AIDS diagnosis rate among males has fluctuated from 2002 to 2006 while the female AIDS diagnosis rate has remained fairly steady from 2002 to 2006, with a slight decrease seen in 2004 and 2005.



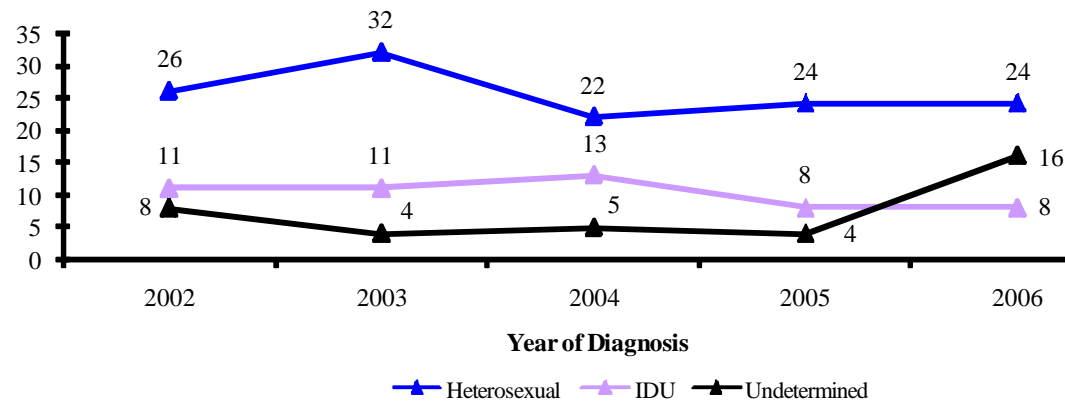
\*Due to the small numbers of AIDS cases reported, rates are not presented for age groups 0-12 and 13-19 years old.

\*\*Data for 2007 and 2008 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays.

Cumulatively through June 30, 2008, the largest percentage of AIDS cases were diagnosed in their 30's (42%), followed by those in their 40's (27%). The AIDS diagnosis rate has been highest among those in their 30's and 40's from 2002 to 2006 (Figure 5). There was a slight increase in the diagnosis rates for all age categories from 2005 to 2006, except among those 30 to 39 years of age.

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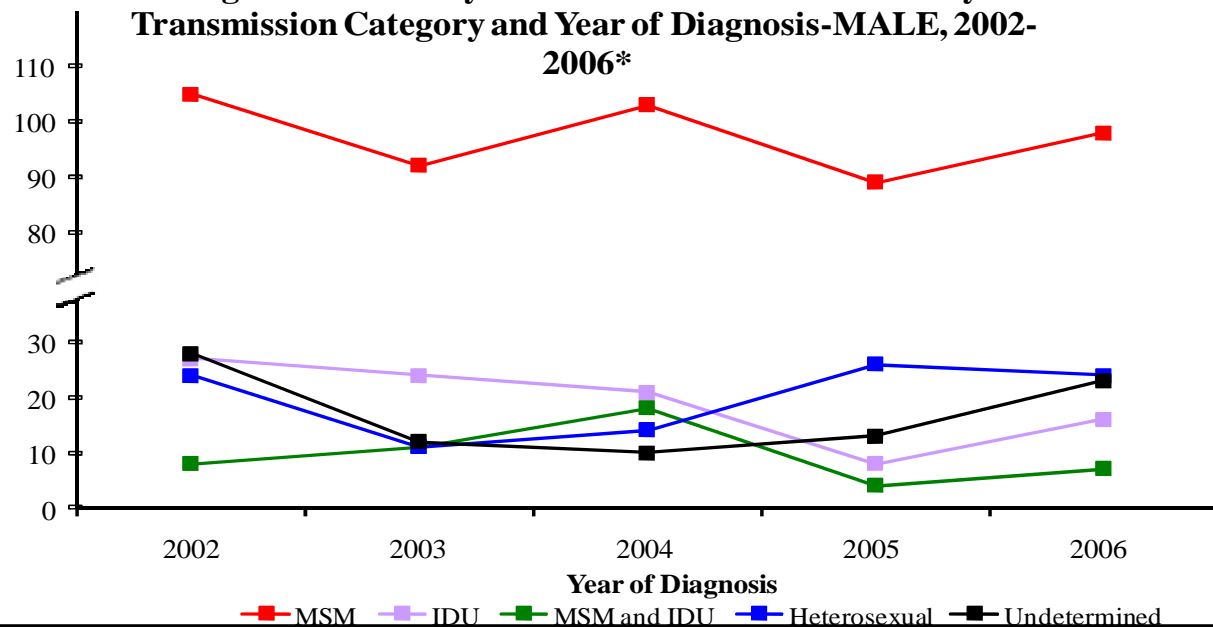
**Figure 6. Kentucky Adult/Adolescent AIDS Cases by Transmission Category and Year of Diagnosis - FEMALE, 2002-2006\***



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Data for 2007 and 2008 are provisional due to reporting delays and are not used in trend analysis; data are subject to change due to reporting delays.

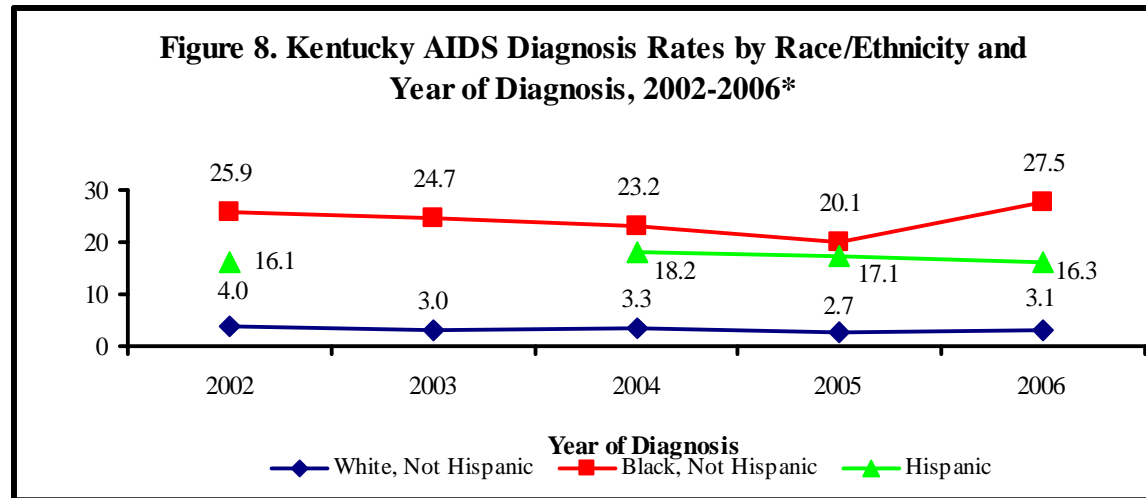
**Figure 7. Kentucky Adult/Adolescent AIDS Cases by Transmission Category and Year of Diagnosis-MALE, 2002-2006\***

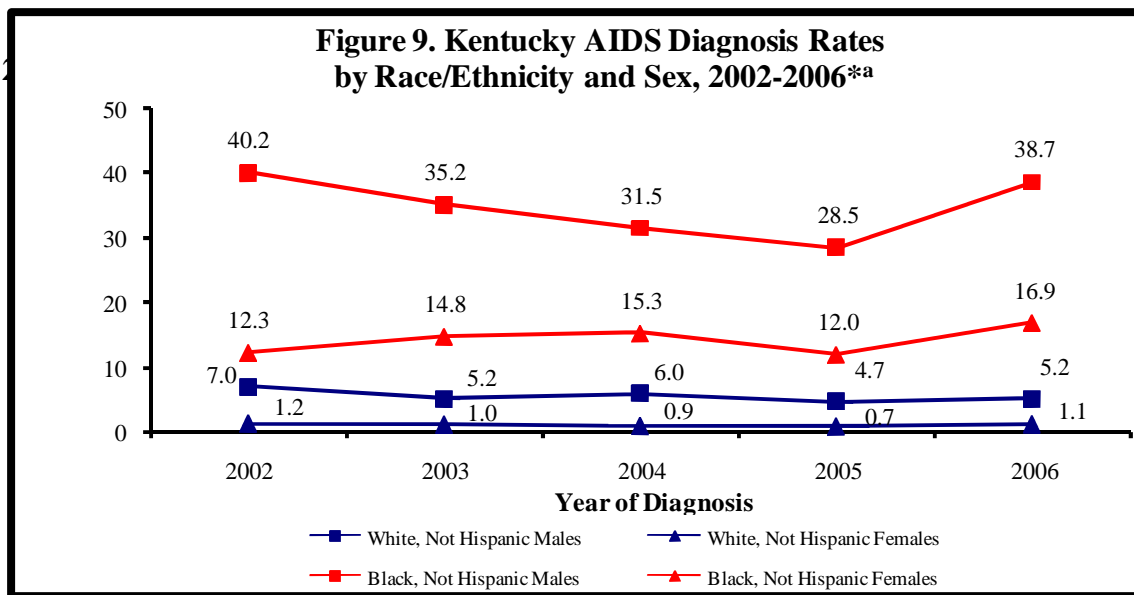


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\*Data for 2007 and 2008 are provisional due to reporting delays and are not used in trend analysis; data are subject to change due to reporting delays.

Figure 6 and Figure 7 show female and male Kentucky adult/adolescent AIDS cases by transmission category and year of diagnosis. The number of cases among females reporting heterosexual contact as the mode of transmission decreased from 2003 to 2004, and remained fairly steady from 2004 to 2006 (Figure 6). Also, the number of female cases reporting IDU as their primary mode of transmission decreased from 2004 to 2005. In Figure 7 for adult/adolescent males, please note the break in the y-axis for the number of cases diagnosed. Among males, MSM's account for the largest number of cases diagnosed each year from 2002 to 2006. The number of males reporting IDU as their primary mode of transmission decreased from 2002 to 2005, and then increased in 2006. The number of cases among males attributed to heterosexual contact increased from 2003 to 2005. Among both females and males the number of cases with an undetermined transmission category increased in 2006.





\*Data in 2007 and 2008 are provisional due to reporting delays and are not used in trend analysis.

<sup>a</sup> Rates for Hispanic cases by sex are not presented due to the small number of cases reported.

On average from 2002-2006, the AIDS diagnosis rate for blacks was approximately eight times higher than for whites, and five times higher for Hispanics than for whites in Kentucky (Figure 8). The diagnosis rate among black males has steadily decreased between 2002 and 2005 (Figure 9). The diagnosis rate among both black males and females increased from 2005 to 2006. This trend will continue to be monitored. The diagnosis rates among white males and females have remained fairly steady from 2002 to 2006 (Figure 9).

#### HIV Diagnoses

Between 2005 and June 30, 2008 there have been a total of 1,234 HIV infections reported in Kentucky (Table 1). Of these cases, 25% were concurrently diagnosed with AIDS during the same calendar month as the initial HIV diagnosis. The number of new HIV infections diagnosed between 2005 and 2007 and the proportion of concurrent diagnoses has remained fairly steady.

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**Table 1. Kentucky HIV Diagnoses, 2005-2008\***

	Total HIV Diagnoses	Without AIDS		Concurrent with AIDS Diagnosis	
Year of Diagnosis	N	N	%	N	%
2005	339	256	76%	83	24%
2006	354	267	75%	87	25%
2007	403	307	76%	96	24%
2008*	138	101	73%	37	27%
<b>Total</b>	<b>1234</b>	<b>931</b>	<b>75%</b>	<b>303</b>	<b>25%</b>

\*Data reported through June 30, 2008

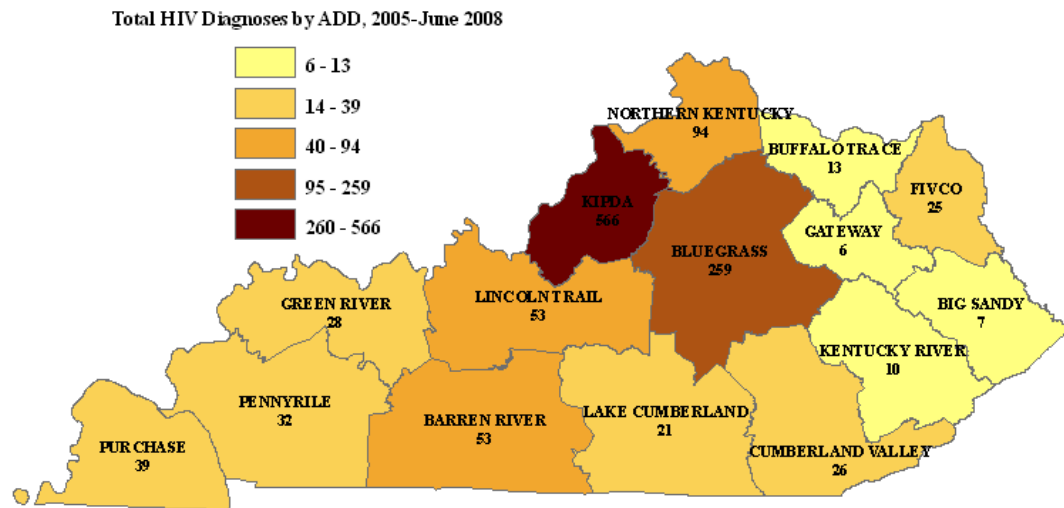
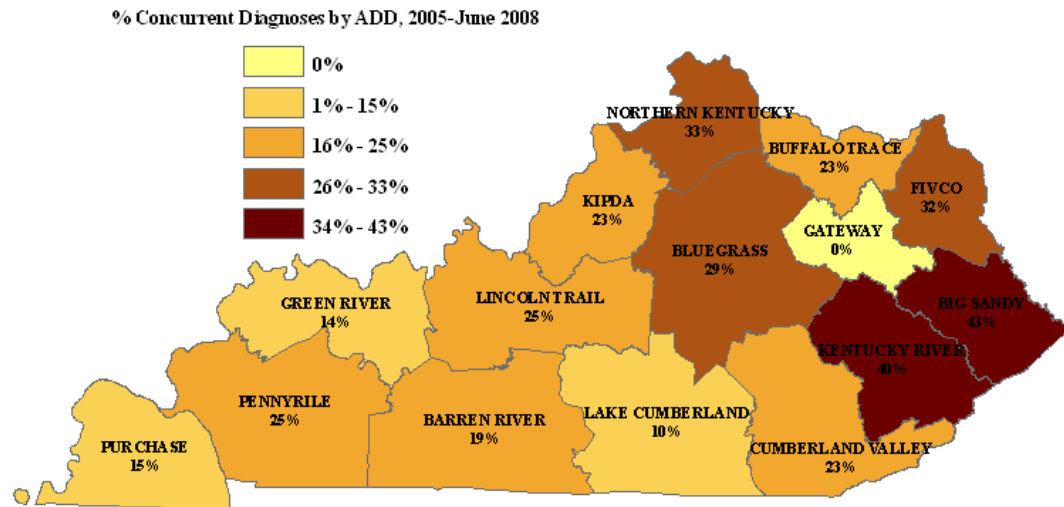


Figure 10 examines the total number of HIV infections diagnosed between 2005 and June 30, 2008 by ADD. The labels on the map represent the total number of HIV infections, regardless of disease progression status in each ADD. The largest number of cases (n=556, 45%) diagnosed in this period were residing in the KIPDA ADD, which includes the city of Louisville. The second largest number of cases (n=259, 21%) were residents of the Bluegrass ADD at the time of diagnosis. The smallest number of HIV infections

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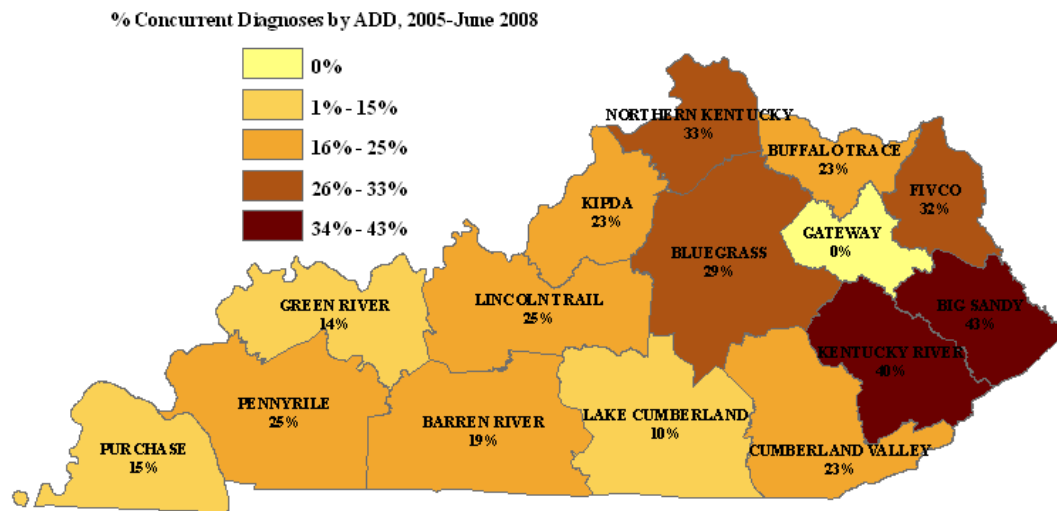
diagnosed and reported during this period occurred in the ADD's located in eastern

Figure11. Percent of HIV Infections Reporting Concurrent Diagnoses with AIDS by Area Development District (ADD) of Residence at Time of Diagnosis, 2005-June 2008

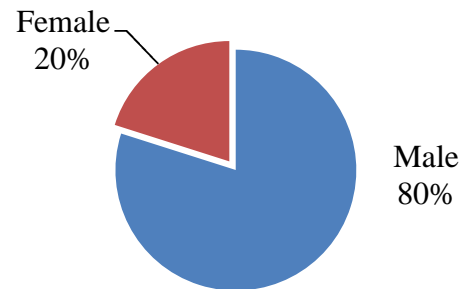


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Figure 11 examines the variation by ADD in the proportion of cases within each ADD diagnosed concurrently with HIV and AIDS from 2005 to June 30, 2008. The proportion of HIV infections diagnosed concurrently with AIDS ranged from 0% to 43% among the ADDs. The greatest proportion of HIV infections diagnosed concurrently with AIDS (43%) occurred in the Big Sandy ADD in eastern Kentucky. However, there were only a total of seven HIV infections diagnosed in this ADD. The ADDs in northern Kentucky also had comparatively higher percentages of concurrent diagnoses.

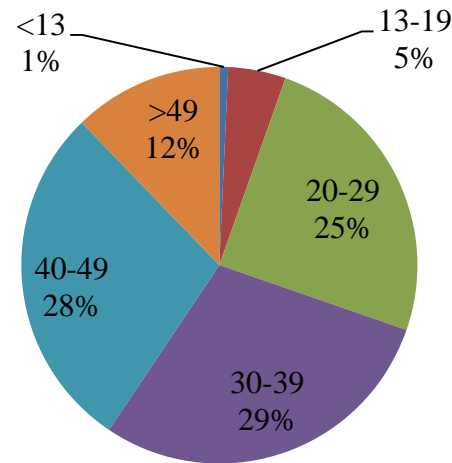


**Figure 12. Percentage of Kentucky HIV Diagnoses by Sex, 2005-June 2008**



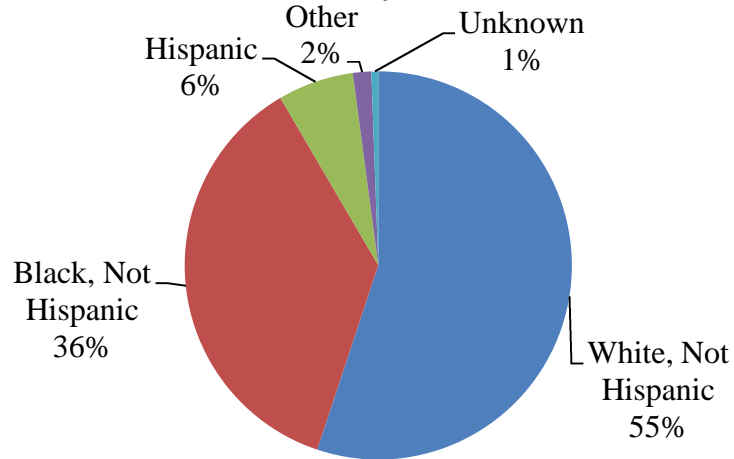
Between 2005 and June 2008, 80% of all HIV diagnoses were reported among males. There were no differences in the distribution by sex between HIV cases diagnosed without AIDS, and cases concurrently diagnosed with HIV and AIDS in the same calendar month.

**Figure 13. Percentage of Kentucky HIV Diagnoses by Age at Diagnosis, 2005-June 2008**



Between 2005 and June 2008, 29% of new HIV diagnoses were reported among those 30-39 years of age (Figure 13). Eight-two percent of all HIV infections diagnosed in this time period were among individuals 20-49 years of age. There were differences in the distribution of age at diagnosis between HIV cases diagnosed without AIDS and cases concurrently diagnosed with HIV and AIDS in the same calendar month. Among individuals diagnosed with HIV without AIDS, 25% of all cases were diagnosed among those 40-49 years of age. In comparison, individuals diagnosed between 40-49 years of age represented 38% of all HIV cases concurrently diagnosed with AIDS. In contrast, individuals diagnosed between 20-29 years of age represented 28% of HIV without AIDS diagnoses, but only represented 14% of all cases concurrently diagnosed with AIDS.

**Figure 14. Percentage of Kentucky HIV Diagnoses by Race/Ethnicity, 2005-June 2008**



Whites represented 55% of all diagnosed HIV infections from 2005 to June 2008 (Figure 14). Blacks and Hispanics are disproportionately impacted by HIV. Although Blacks and Hispanics comprise only 7% and 1% of Kentucky's general population, respectively, based on 2000 U.S. Census data, they represent 36% and 6% of all new HIV diagnoses from 2005-2008. Hispanics made up a larger proportion (11%) of concurrently diagnosed cases than their proportion (5%) among individuals diagnosed with HIV without AIDS. This data suggests that Hispanics are being diagnosed and reported at a later stage than other race/ethnicity categories.

**Figure 15. Percentage of Kentucky HIV Diagnoses by Transmission Category-Adult/Adolescent Males, 2005-June 2008**

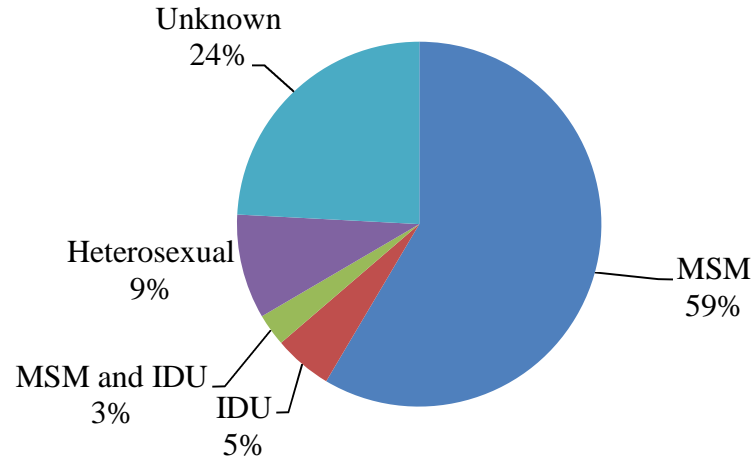


Figure 15 illustrates the distribution of HIV diagnoses from 2005 to June 2008 by transmission category among adult/adolescent males. The majority of HIV diagnoses within this time period have been attributed to men who have sex with men (59%). There are a large percentage of cases where the transmission category is unknown (24%). Cases with unknown transmission category information have not been proportionately re-distributed. The large percentage of missing cases makes it difficult to interpret this data.

**Figure 16. Percentage of Kentucky HIV Diagnoses by Transmission Category-Adult/Adolescent Females, 2005-June 2008**

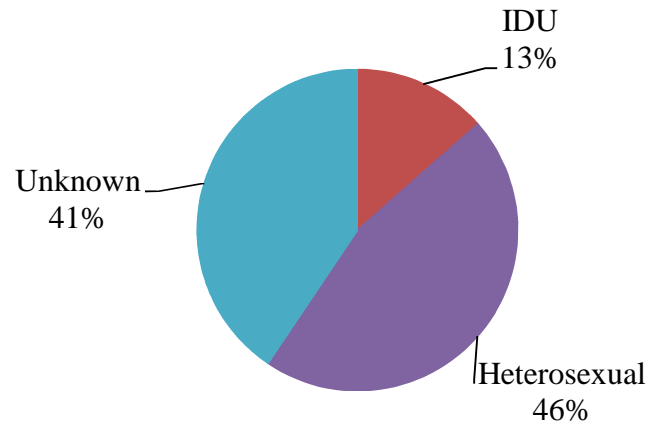


Figure 16 illustrates the distribution of HIV diagnoses from 2005 to June 2008 by transmission category among adult/adolescent females. The majority of HIV diagnoses within this time period have been attributed to heterosexual contact (46%). There are a large percentage of cases where the transmission category is unknown (41%). Cases with unknown transmission category information have not been proportionately re-distributed. second highest proportion of living AIDS cases as of December 31, 2006 (21.1%) and new AIDS cases diagnosed between January 1, 2005 and December 31, 2006 (21.0%). There has been little change in the distribution of living AIDS cases and new AIDS cases by residence at diagnosis between 2004 and 2006. See the map below for the distribution of 2006 prevalence rates by ADD.

### 3. Comprehensive Plan Emerging Communities (EC)

The North Central Area Development District (ADD) which includes the city of Louisville is the residence of diagnosis for 1,157 (48%) of persons living with AIDS as of June 30, 2008. 520 (45%) of Black (non-Hispanics) living with AIDS are residing in this ADD as well as 31 (3%) of Hispanics. 603 (52%) of people with Men who have Sex with Men (MSM) exposure, 133 (11%) who inject drugs (IDU) as well as 236 (20%) with heterosexual exposure reside in the North Central ADD.

The direct services coalition prioritizes EC-funded services according to the needs of the local groups with the largest percentage of AIDS incidence in the seven (7) county region surrounding Louisville which includes four (4) Indiana counties (Clark, Floyd, Harrison, and Washington). According to the current Kentucky epidemiologic profile, majority of AIDS cases diagnosed in Kentucky reside in the North Central ADD. Cumulatively, there were 1,157 (45%) of total living AIDS cases as of June 30, 2008 in this region. In 2006 and 2007, there were 77 and 100 incident (new) living AIDS cases respectively residing in the ADD at the time of diagnosis. Though the area is predominantly white, just like the rest of the state, the populations disproportionately affected by the epidemic include minorities and certain risk categories as shown by the data below. “Black, Non Hispanics” represent 33% of living AIDS cases in the North Central ADD, while accounting for only 7.5% of the total Kentucky population. Hispanics on the other hand comprise 2% of the entire Kentucky population, while there are 5% living Hispanic AIDS cases. The majority of living AIDS cases in Kentucky report their mode of exposure as Men who have Sex with Men (MSM) (52%), followed by persons with high risk heterosexual contact at 20% and Injecting drug users (IDU) at 12%.

<http://www.census.gov/popest/states/asrh/SC-EST2007-03.html>

Data from the Indiana State Department of Health shows that within the four Indiana counties in the EC region (Clark, Floyd, Harrison, and Washington), the number of people living with AIDS as of June 30, 2008 was 331 (4%), with over half residing in Clark County 184. In all four Indiana Counties, 186 (56%) of living AIDS cases were from the MSM exposure category and 46 (14%) were from the Heterosexual category. The majority of people living with HIV disease in this area are male (275), White (248) and Black (non-Hispanic) (71). However, Indiana is predominantly White (88%), so this explains the large proportion of infections among the White population. Blacks however, comprise 9% of the total Indiana population but accounted for 21% of total cases in the region.

[http://www.in.gov/isdh/files/index\\_jun\\_08.pdf](http://www.in.gov/isdh/files/index_jun_08.pdf)

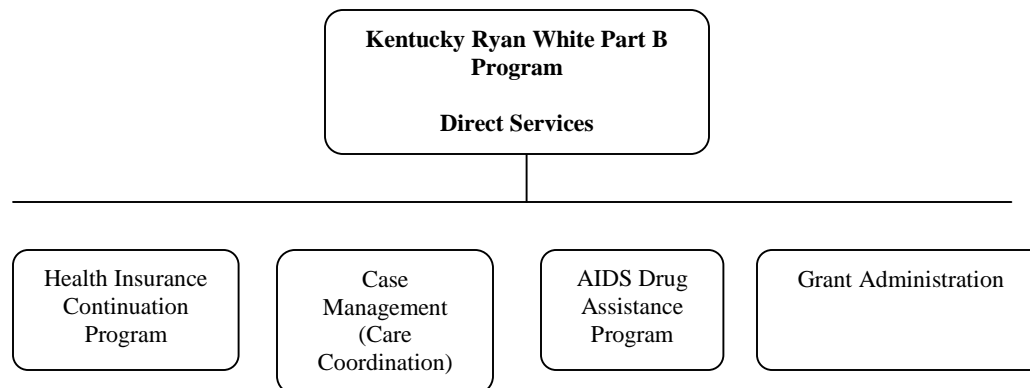
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Emerging Community (EC) funds are currently utilized to particularly target the above mentioned groups that are adversely impacted by the disease. The comprehensive plan also includes activities targeting the populations with the highest percentage of unmet need as shown in the unmet need framework, including: African Americans; Hispanics; Men who have Sex with Men; Injection Drug Users (IDU) and high risk heterosexuals by providing timely linkages to services, care and treatment for these emerging populations.

\* ADD means Area Development District. In Kentucky, there are fifteen. Conceptually, they were formed by local elected officials and citizens in the Commonwealth to find collaborative means to deal with problems that beset their communities. For more information about ADDs, visit <http://kycadd.org/index.html>

### 4. Description of the Current Local, State, and/or Regional Response to the Epidemic: See Epidemiological Profile in Section 2

#### Illustration 1. Direct Services Components



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### **Kentucky Direct Services**

#### Kentucky Health Insurance Continuation Program

The Kentucky Health Insurance Continuation Program (KHICP) is a direct service component of the Kentucky Care Coordination Program (KHCCP). This program provides payments for the continuation of health insurance benefits for eligible individuals at risk of losing their employment-related or private-pay insurance.

KHICP is largely federally funded, and is a “payor of last resort” program for participants. KHICP assistance is not guaranteed and payments cannot be made directly to participating clients. The six (6) regional contractors of the KHCCP provide local assistance to clients with insurance related matters, including payments for insurance premiums. KHICP services may differ among KHCCP regions depending on the funding and service priorities.

#### Kentucky HIV/AIDS Care Coordinator Program/Direct Services

It is mandatory for all participants in the Direct Services programs in Kentucky to enroll in case management through the KHCCP. Case management addresses client needs and monitors progress of client goals outlined in the Individualized Care Plan (ICP). The ICP includes a variety of medical, personal, mental, and socioeconomic goals. Both the Care Coordinator and the client are expected to comply with the goals of the ICP. Three of the six KHCCP regions operate within a “one stop shop” facility, providing Ryan White Part B services, Part C (medical treatment), mental health and HIV prevention services. This model allows for clients to receive prevention services, case management and medical care on the same day at one facility, minimizing travel and other expenses. The other three (3) KHCCP regions that are not housed within a Part C clinic, arrange Care Coordinator schedules to ensure that Part B case management services are always available.

#### Kentucky AIDS Drug Assistance Program (KADAP)

The Kentucky AIDS Drug Assistance Program (KADAP) was created in 1990 as a result of the Ryan White CARE Act. KADAP is a centrally administered program that provides HIV/AIDS medications and medications for the treatment of opportunistic infections to low-income HIV+ Kentuckians. KADAP contracts with the University of Kentucky (Kentucky Clinic Pharmacy), as the sole provider of medications for clients. Eligible clients can receive KADAP formulary medications via mail-order or walk-in pharmacy services. Participants access KADAP services through the Kentucky HIV/AIDS Care Coordinator Program (KHCCP). Care Coordinators regularly coordinate their work schedules to be present on-site at clinics, to assist potential clients with applications for KADAP and emergency medications. Care Coordinators from the Northern Kentucky region do not work on-site at a Part C medical treatment clinic. This service area borders Ohio and coordinates with the Part C clinic at the University of Cincinnati to facilitate prompt access

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to medications. In addition, each region has established relationships with private Infectious Disease medical providers in their respective area to provide linkage to care.

### Grant Administration

Each component of the Kentucky Direct Services program has a designated administrator within the state HIV/AIDS Branch. Each program component is administered from the Kentucky Cabinet for Health and Family Services' HIV/AIDS Branch. The Grant Administrator receives continuous monthly expense reports regarding all Part B direct services agencies. Monthly invoices are submitted by the fifteenth (15<sup>th</sup>) of each month, detailing expenses for reimbursement. Contracted local health departments submit expense report in the same manner. In addition, the Grant Administrator is responsible for all applicable federal and State reporting requirements, budget formulation, expense monitoring, contracting procedures, and other program planning and implementation activities.

## **5. Assessment of Statewide Needs**

The process for assessing the needs of HIV infected individuals in the state included the 2008 Kentucky Statewide Coordinated Statement of Needs, the 2007 Statewide Prevention and Care Needs Assessment, the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC), the 2008 HIV Prevention Plan, the 2005 Comprehensive Plan, the 2007 African American Needs Assessment, comments from HIV/AIDS Providers, anecdotal evidence, and epidemiological data.

### **(a.) Need for Primary Medical Care and Core Medical Services:**

Identified need for Primary Medical and Core Medical Services includes the development of a Discharge Planning program within the Kentucky state prison system. The 2008 SCSN stated that HIV + inmates discharged from the state prison system lack poor or no follow-up for medical care services and medical case management. The state will begin to collaborate with the LaGrange prison facility- the state prison housing the largest population of HIV infected inmates, to develop an HIV education, prevention and discharge planning program for HIV + inmates who will be released.

The Kentucky Part B program has limited funds to provide client transportation for medical and case manager appointments. Due to the high gas prices and adhering to HRSA's 75/25 rule, regions experienced reduced funding for transportation services. In recent

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client surveys, needs assessments, and the current SCSN, clients identified less assistance for transportation to travel to medical and case manager appointments as a significant need.

The 2008 SCSN identified a need for education and training for Part B case managers, including areas of cultural competency, medical case management, fiscal monitoring and on Client Level Data requirements.

Strategies to better address mental health and substance abuse issues with Part B clients was identified in both the 2008 SCSN and the 2007 Statewide Needs Assessment. Clients and providers reported a lack of competency on the part of mental health and substance abuse providers when treating patients who are also HIV positive.

Ryan White Part C clinicians noted that quality improvement activities tax existing human and financial resources. Though Clinical Quality Improvement measures for clinical care are in place, but the ability to hold meetings and document quality improvement places a burden on care providers. Clinician would benefit from coordinated technical assistance.

Oral health care continues to be problematic for HIV positive individuals due to the physical nature of HIV disease and barriers that keep individuals from seeking oral health treatment from private dentists. Barriers cited include discrimination, affordability, fear of disclosure of HIV status, lack of insurance and lack of accessible providers.

Additionally, Part C clinicians noted the need for collaboration with Kentucky's Part F clinic to provide dental education training to all Part C clinicians.

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**(b.) KENTUCKY UNMET NEED ESTIMATE AND ASSESSMENT**  
**RYAN WHITE CARE ACT TITLE II: FY2008 GRANT APPLICATION**  
**Unmet need Framework for the year 2007: Ryan White Part B Program**

Population Sizes		Value		Data Source(s)
Row A	PLWA <sup>1</sup>	2,543		HARS
Row B	PLWH <sup>2</sup> , non-AIDS	1,603		HARS
Row C	Total PLWH/A <sup>3</sup>	4,146		HARS
Care Patterns		Value		Data Source(s)
Row D	Number of PLWA who received HIV primary medical care during the 12-month period January 1, 2007-December 31, 2007	1,706		Laboratory database, Ryan White Part B Program. Number of persons living with HIV who had a Elisa, Western blot, PCR, HIV antigen or HIV culture, CD4+ assays HIV viral load assays, a positive serologic test result for HIV infection or care through the Ryan White Part B Program in the 12 month period.
Row E	Number of PLWH/non-AIDS who received the specified HIV primary medical care during the 12-month period January 1, 2007 - December 31, 2006	1,129		Laboratory database, Ryan White Part B Program. Number of persons living with HIV who had a Elisa, Western blot, PCR, HIV antigen or HIV culture, CD4+ assays HIV viral load assays, a positive serologic test result for HIV infection or care through the Ryan White Part B Program in the 12 month period.
Row F	Total number of PLWH/A who received the specified HIV primary medical care during the 12-month period January 1, 2007 - December 31, 2007	2,835		Laboratory database, Ryan White Part B Program. Number of persons living with HIV who had a Elisa, Western blot, PCR, HIV antigen or HIV culture, CD4+ assays HIV viral load assays, a positive serologic test

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				result for HIV infection or care through the Ryan White Part B Program in the 12 month period.
	<b>Calculated Results</b>	<b>Value</b>	<b>Percent</b>	<b>Calculation</b>
Row G	Number of PLWA who did <b>not</b> receive the specified HIV primary medical care	837	33%	Value = A - D Percent = G/A
Row H	Number of PLWH/non-AIDS who did <b>not</b> receive the specified HIV primary medical care	474	30%	Value: B - E Percent: H/B
Row I	Total PLWH/A <b>not</b> receiving the specified HIV primary medical care (quantified estimate of unmet need)	1,311	32%	Value: G + H Percent: I/C

<sup>1</sup> People living with AIDS

<sup>2</sup> People living with HIV- not AIDS

<sup>3</sup> People living with HIV and/or AIDS

Data are current as of June 30, 2008, therefore not similar to the data presented in the epidemiologic profile. These tables compare persons living with HIV and/or AIDS with met need to those with unmet need through laboratory data and Ryan White Part B Program data.

### Narrative Description

#### **Data Sources and Estimation Methods Used:**

The following methodology was used in order to estimate unmet need for HIV-related primary care in Kentucky.

First, three databases were selected:

- *The HIV/AIDS Reporting System (HARS)*. HARS is the surveillance database that contains information on reported cases of HIV/AIDS in Kentucky. Cases entered in HARS were either diagnosed in the state of Kentucky or are currently living in the state since being diagnosed. HARS contains the population-based data needed to determine the population size of HIV-infected persons.

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- *Laboratory Database.* Mandatory laboratory reporting in Kentucky for all HIV positive tests include Elisa, Western blot, PCR, HIV antigen or HIV culture, CD4+ assays including absolute CD4+ cells and CD4%, HIV viral load assays and a positive serologic test result for HIV infection. These laboratory results are contained in an ACCESS database maintained by the HIV Surveillance program.
- The Ryan White Part B Program datasets comprise of Kentucky AIDS Drug Assistance Program (KADAP) data which contains utilization data for clients who receive one or more pharmaceutical services in the Program and care coordinator data that tracks demographics and client utilization of the core and supportive services through the program.

Second, “care” was defined as having a laboratory result Elisa, Western blot, PCR, HIV antigen or HIV culture, CD4+ assays HIV viral load assays and/or a positive serologic test result for HIV infection during the 12 month time period (January 1, 2007 through December 31, 2007) among patients in HARS. Use of anti-retroviral therapy was not included in the definition of care because HIV Surveillance does not collect this information routinely. However, it is believed that the vast majority of patients on medication regularly have CD4 and viral load tests to measure compliance and effectiveness. There are few, if any, patients in care who are missed using laboratory data only.

Third, laboratory data were used to determine each patient’s most recent Elisa, Western blot, PCR, HIV antigen or HIV culture, CD4+ assays HIV viral load assays and/or a positive serologic test result test date. These laboratory results were then joined to surveillance data in HARS including all living cases diagnosed with HIV/ AIDS in Kentucky. Persons diagnosed after December 31, 2007 were excluded from analysis to eliminate the possibility of including those who were recently diagnosed and had not yet established care. Unmet need was then calculated by determining the number of persons in HARS who were diagnosed prior to December 31, 2007, were living in Kentucky and had not received a laboratory result between January 1, 2007 and December 31, 2007.

Fourth, Ryan White Part B Program Data were used to further determine persons in HARS who had no record of laboratory tests in the laboratory database but who received HIV related primary care through the program. All HARS cases with no record in the laboratory database were matched against the program’s data to confirm whether they had received care in the mentioned period.

### Limitations:

While the combination of surveillance, laboratory and Ryan White data offers an ideal way to measure unmet need, there are some limitations to the data that should be noted. The current system of recording cases into HARS has a limited way of identifying those who are being served in other states. Kentucky is bordered by seven states. It is common that treatment is sought in the nearest

## **2009 Kentucky Statewide Comprehensive Plan**

medical facility, which may be in a neighboring state. Unless the labs are done by a reference laboratory, there is no way to ensure that all labs being performed in private institutions are being reported to Kentucky Surveillance. There inevitably is room for error in the laboratory reporting system however; statistical quality checks are in place to ensure the quality of those.

Although the Framework requests the number of persons who are aware of their status, HIV/AIDS surveillance is not able to capture HIV status awareness. Thus, the estimates in the Framework include all persons reported to surveillance and living in Kentucky, whether aware of their status or not. In addition, in and out migrations were unaccounted for due to the application's (HARS) inability to effectively track people's physical addresses over time. This may slightly adjust the numbers of those falling under the unmet need category due to the mobility of persons receiving care in and out of the state of Kentucky. The numbers are lower than the data shown in the Epidemiologic profile due to different HIV/AIDS diagnosis date restrictions (only people diagnosed with HIV disease by December 31, 2007), and the recently completed process of comparing (matching) Kentucky Medicaid and state HIV/AIDS records. We are currently matching those not in care through the laboratory database and the Ryan White Part B Program with Medicaid data, and hope to have an adjusted unmet need estimate for the comprehensive plan.

### ***Assessment of Unmet Need: Analysis of Those Not in Care***

The Unmet Need Framework shows that for the time period January 1, 2007- December 31, 2007 there were an estimated 1,603 persons living with HIV and 2,543 persons living with AIDS for a total of 4,146. There were 2,835 people estimated to have been in care during the year 2007 with 1,129 having HIV non-AIDS and 1,706 having AIDS. There were 1,311 (32%) people living with HIV and/or AIDS estimated to be out of care. Of these, 837 (33%) were living with AIDS and 474 (30%) were living with HIV not-AIDS.

Of the 1,311 persons with unmet need, 1,082 (83%) were male and 229 (17%) were female. The majority of persons with HIV and/or AIDS, with unmet need were white, non-Hispanic 727 (55%), followed by black, non-Hispanic 487 (37%). Among Hispanics, 77 (6%) had unmet need in the year 2007. Persons with unmet need were more likely to live in the KIPDA ADD which includes the city of Louisville 585 (45%), Bluegrass ADD which includes the city of Lexington 246 (19%) and Northern Kentucky ADD 165 (13%). Additionally, young adults and middle aged people at the time of HIV and/or AIDS diagnoses had higher rates of unmet need in comparison to other age groups: [491 (37%) among 30-39 year olds; 409 (31%) among 20-29 year olds; and 276 (21%) among those 40-49 years old]. Lastly, the proportion of unmet need was highest among persons reported in these primary transmission categories: MSM (Men who have Sex with Men) 649 (50%); Heterosexual 222 (17%); IDU (Injection Drug Use) 177 (14%); and undetermined modes of HIV transmission 178 (14%).

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ADD means Area Development District. In Kentucky, there are fifteen. Conceptually, they were formed by local elected officials and citizens in the Commonwealth to find collaborative means to deal with problems that beset their communities. For more information about ADDs, visit <http://kycadd.org/index.html>

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### **(c.) Gaps In Care:**

Medicaid/Medicare provides the largest funding sources for HIV/AIDS care and treatment in the state. This indicates a pertinent need for on-going collaborations with the Kentucky HIV/AIDS Branch. The Kentucky Department for Public Health focuses on providing access to care, services and treatment to eligible individuals. Collaborations between HIV, STD, Immunizations, TB, and, Maternal and Child Health would reduce service duplication, maximize resources, and increase program effectiveness.

Lack of cultural competency, stigmatization of HIV infected persons, lack of timely awareness of HIV status, gaps in linkages and retention in care, and inadequate HIV awareness for Hispanics, homeless persons, African Americans, and those with mental health and substance abuse issues are identified gaps in accessing care. Enhanced focus in these areas will narrow the gap in care and treatment.

### **(d.) HIV Prevention Needs**

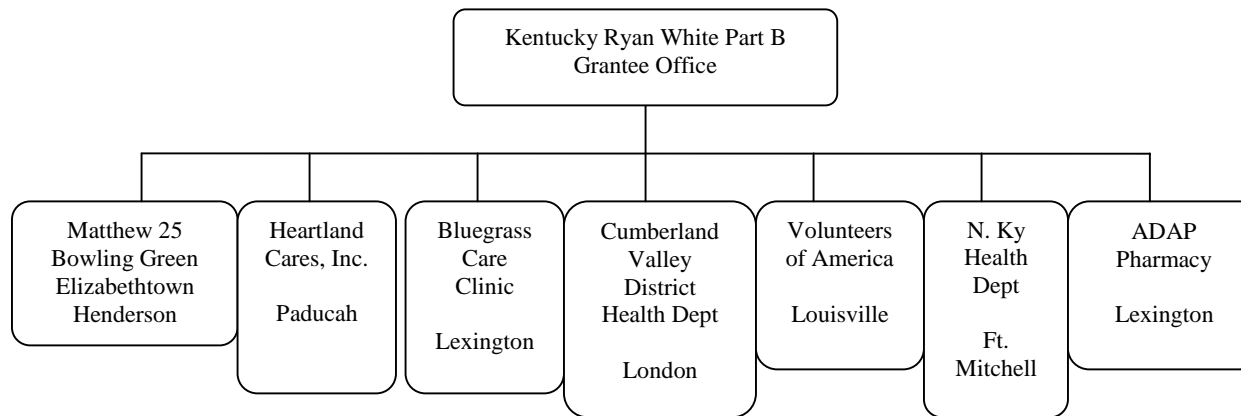
Kentucky law requires Counseling and Testing training for any individual who conducts an HIV test. The Kentucky training calendar should be accessible to various disciplines to provide access and certification for this purpose. Information on HIV prevention activities is not widely publicized or regularly posted on the Kentucky HIVAIDS website. Lack of available information to the types of prevention activities occurring across the state continues to create gaps and barriers to effective prevention awareness. The absence of partnerships with African-American churches and indigenous minority organizations has perpetuated misconceptions of HIV disease and the associated risk factors, leading to increased stigma and ineffective prevention messages.

## **5. Current Continuum of Care**

Kentucky has six (6) Part B direct services regions designed to provide local access to HIV/AIDS care and services statewide. Every individual who receives direct services in Kentucky is assigned a Care Coordinator. This is the mechanism by which clients receive mandatory medical case management and an Individual Care Plan (ICP) is developed for each client and is tailored to their respective needs. This process involves a review of the clients' specific medical and supportive needs, including a mental health and substance abuse assessment. Other factors such as income level, housing status, social and family support systems, individual risk factors, etc., are also evaluated for the ICP. The Care Coordinator and the client work collaboratively to achieve the goals of the ICP, and referrals are made through a network of pertinent service providers in each region.

An introduction to the six (6) Kentucky direct services providers are provided below, as well as descriptions of how each region provides continuum of care.

**Illustration 2. (Locations of Kentucky Part B Programs)**



**1. Bluegrass Care Clinic/BCC (Central and Eastern Region, Lexington, Ky.)**

- This agency operates as a “one stop shop”, providing Ryan White Part B services, Part C (medical treatment), mental health and HIV prevention services. This model allows for clients to receive case management, prevention services and medical care on the same day at one facility, minimizing travel and other expenses. BCC is a clinic on the campus of the University of Kentucky Hospital. This proximity expedites client access to high quality care of various disciplines, such as ophthalmology and renal services.
- BCC coordinates with the Lexington Fayette County Health Department to provide HOPWA (Housing Opportunities for People with AIDS) services. Other linkages include Movable Feast, Comprehensive Care, other private infectious disease physicians, and oral health providers.

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- To ensure the provision of medical services to underserved regions of north eastern Kentucky, BCC has partnered with the Tri-State Infectious Disease Clinic for client care.
- BCC also refers clients to the Portsmouth, Ohio Health Department, which provides treatment for infectious disease patients.

### **2. Cumberland Valley District Health Department / CVDHD (Eastern Region, London, Ky)**

- The CVDHD receives Part B funding for Direct Services to clients in the eastern region of the state.
- Also, CVDHD maintains a Memorandum of Understanding (MOU) with the BCC to provide onsite medical case management for CVDHD clients in the absence of a CVDHD Care Coordinator
- CVDHD receives HOPWA funding for the eastern part of Kentucky. HOPWA funding subsidizes the costs associated with securing safe and affordable housing for clients.
- Prevention services are available through collaborations with the Lexington Fayette County Health Department and Volunteers of America, Lexington, Kentucky.

### **3. Heartland Cares, Inc. (Western Region, Paducah, Ky)**

- Heartland Cares operates as a “one stop shop”, providing Ryan White Part B services, Part C (medical treatment), mental health and HIV prevention services. This model allows for clients to receive case management, prevention services and medical care on the same day at one facility, minimizing travel and other expenses.
- Due to the remote location of this agency, Heartland Cares has developed a referral network of oral health providers.
- Heartland Cares receives HOPWA funding for the western part of Kentucky. HOPWA funding subsidizes the costs associated with securing safe and affordable housing for clients.
- Heartland Cares receives separate funding from the State to provide HIV prevention initiatives, and linkages are in place to provide a broad spectrum of HIV prevention services, including HIV testing and risk reduction.

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- Linkages have been established with the regional Comprehensive Care system. The Comprehensive Care system is comprised of facilities able to treat physical and mental health conditions, including substance abuse.

### **4. Matthew 25 AIDS Services, Inc. (Western and South Central, Henderson, Ky)**

- Matthew 25 operates as a “one stop shop”, providing Ryan White Part B services, Part C (medical treatment), mental health and HIV prevention services located at the main office in Henderson. This model allows for clients to receive case management, prevention services and medical care on the same day at one facility, minimizing travel and other expenses.
- Matthew 25 also has offices located in Bowling Green and Elizabethtown providing Direct Services to clients in each of these locations. Both of these offices have established referral networks with private Infectious Disease physicians. Referrals are made to the regional Comprehensive Care system, which is comprised of facilities able to treat physical and mental health conditions, including substance abuse.
- Oral health services are provided to Matthew 25 clients through a Memorandum of Understanding (MOU) with the Part F clinic at the University of Louisville and their satellite office located in Elizabethtown.
- To enhance client access in this large service area, this agency has partnered with the Daviess County Health Department in Owensboro. In this partnership, Matthew 25 has been allotted meeting space, at the health department, allowing for weekly meetings between Matthew 25 Care Coordinators and area clients. At the health department, clients can receive case management and medical care on the same day at one facility, minimizing travel and other program expenses.
- This agency utilizes the University of Louisville’s Elizabethtown Part F program (oral health services) as a referral source. In addition, there is a Care Coordinator at the Elizabethtown office who is available to clients at this location.
- Matthew 25 receives direct funding from the CDC to provide HIV prevention testing, risk reduction, prevention initiatives, and linkages to care.

**5. Northern Kentucky Independent District Health Department (NKIDHD) (Northern Region, Ft. Mitchell, Ky)**

- The NKIDHD receives Part B funding for Direct Services in the northern region of the state.
- The NKIDHD is located in the far northern part of Kentucky bordering Cincinnati, Ohio. As a result, many client medical referrals are made to the University of Cincinnati Part C medical clinic. Clients are also referred to private Infectious Disease physicians within the northern Kentucky area.
- This agency also receives a small amount of federal funding for HOPWA. The HOPWA funds subsidize the costs associated with securing safe and affordable housing for clients.
- An MOU currently exist between this health department and the Droege House. The Droege House is a residential facility in Dayton, Ohio, specializing in substance abuse issues. This facility accommodates HIV positive individuals only.
- Referrals are made to the regional Comprehensive Care system, which is comprised of facilities able to treat physical and mental health conditions, including substance abuse.
- Collaborations with a Disease Investigative Specialist (DIS) and Prevention Specialists provide HIV testing, partner notification, risk reduction counseling, and prevention initiatives for clients.

**6. Volunteers of America (VOA) (Louisville Region, Louisville, Ky)**

- VOA receives Part B funding for Direct Services in the Louisville area of the state.
- The Louisville area contains the largest number of HIV infected individuals in the state. Therefore, VOA provides services to the largest number of clients within the state.
- VOA has a standing MOU with the University of Louisville “WINGS” (Part C) medical clinic and routinely refers clients to that location for treatment. Also, VOA has a Care Coordinator housed at the Part C clinic. At this location, clients can receive case management from VOA and medical care on the same day at one facility, minimizing travel and other program expenses.

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- VOA is part of the AIDS Services Organization (ASO) in Louisville. This organization consists of all of the HIV/AIDS service organizations in the Louisville/Jefferson County area and provides an extensive referral network for client care. The ASO is in charge of the yearly Louisville AIDS Walk. The money raised is then distributed among the ASO partners to supplement funds for assistance of HIV infected individuals.
- Collaborations with Seven Counties, VOA Substance Abuse, Louisville/Metro Health Department and House of Ruth have been established to provide care and services. This collaboration allows service gaps to be filled for residential and non-residential substance abuse and mental health treatment.
- This agency refers clients to the University Of Louisville School Of Dentistry (Part F) for oral health needs.
- VOA is the sole recipient of Emerging Communities (EC) funding through the Ryan White Part B program in the state. E.C. funds provide medication assistance, labs/x-rays, housing, food and other supportive services to a variety of local agencies in the service region. EC funds also serve eligible clients in four Indiana counties that border the Louisville/Jefferson county area by establishing an MOA with the Hoosier Clinic in Jeffersonville, Indiana. This MOA provides funding to the clinic in order to subsidize medical treatment for referred clients.
- Bi-lateral referrals for prevention and STD specialty care are conducted between VOA and the Louisville/Metro Health Department, which are all on the same floor of the same facility for easier client access.

### 7. Resource Inventory- Summary description of organizations and individuals providing services accessible to people living with HIV in the service are (by Core and Support service categories)

<u>Code</u>	<u>Service</u>	<u>Code</u>	<u>Service</u>	<u>Code</u>	<u>Service</u>
1a	Outpatient /Ambulatory Health Services	2a	Case Management (non-Medical)	2n	Respite Care
1b	AIDS Drug Assistance Program (ADAP) Treatments	2b	Child Care Services	2o	Substance Abuse Residential
1c	AIDS Pharmaceutical Assistance (local)	2c	Emergency Financial Assistance	2p	Treatment Adherence Counseling
1d	Oral Health Care	2d	Food Bank/Home-Delivered Meals		
1e	Early Intervention Services	2e	Health Education/Risk Reduction		
1f	Health Insurance Premium & Cost Sharing Assistance	2f	Housing Services		
1g	Home Health Care	2g	Legal Services		
1h	Home and Community-based Health Services	2h	Linguistics Services		
1i	Hospice Services	2i	Medical Transportation Services		

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1j	Mental Health Services	2j	Outreach Services
1k	Medical Nutrition Therapy	2k	Psychosocial Support Services
1l	Medical Case Management (including Treatment Adherence)	2l	Referral for Health Care/Supportive Services
1m	Substance Abuse Services—outpatient	2m	Rehabilitation Services

Organization Name	Organization Address	City	State	Zip	Phone	Service Codes (see section 1.7)
AHEC/HETC-COVINGTON	1030 OLD STATE RD	PARK HILLS	KY	41011	(859) 442-1191	2e
AHEC/HETC-LEXINGTON	498 GEORGETOWN ST	LEXINGTON	KY	40508	(859) 281-6086	2e
AHEC/HETC-LOUISVILLE	2215 PORTLAND AVE	LOUISVILLE	KY	40212	(502) 772-8113	2e
AIDS INTERFAITH MINISTERIES (AIM)	850 BARRETT AVE STE 302	LOUISVILLE	KY	40204	(502) 574-6086	2K, 2J, 2L
AIDS SERVICES CENTER COALITION (ASCC)	810 BARRET AVENUE STE 305	LOUISVILLE	KY	40204	(502) 561-8824	2L
AIDS VOLUNTEERS INC (AVOL)	263 NORTH LIMESTONE ST	LEXINGTON	KY	40507	(859) 225-3000	2L, 2e2f, 2g
AIDS VOLUNTEERS OF NORTHERN KENTUCKY (AVNK)	PO BOX 175743	COVINGTON	KY	41017	(859) 512-7925	2L, 2e2f, 2g
AMERICAN RED CROSS (ARC)	520 EAST CHESTNUT ST	LOUISVILLE	KY	40202	(502) 589-4450	2d, 2e, 2j, 2L
BARREN RIVER DISTRICT HEALTH DEPARTMENT	PO BOX 1157	BOWLING GREEN	KY	42102	(270) 781-8039	1a, 1e, LL, 2e, 2g, 2k, 2L, 2p, 2h
BLUEGRASS COMMUNITY HEALTH CENTER	1306 VERSAILLES ROAD, SUITE 120	LEXINGTON	KY	40509	(859) 259-0717	1a, 1e, 1h, 1k, 2a, 2e, 2h, 2j, 2k, 2L, 2p
BLUEGRASS REG MENTAL HEALTH/MENTAL RETARDATION BOARD	1351 NEWTOWN PIKE	LEXINGTON	KY	40511	(859) 253-1686	1j, 2k, 2L
CHRYSLIS HOUSE	1589 HILL RISE DR	LEXINGTON	KY	40504	(859) 255-0800	1j, 1m, LL, 2a, 2p

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COUNCIL ON PREVENTION AND EDUCATION SUBSTANCES (COPEs)	845 BARRET AVE	LOUISVILLE	KY	40204	(502) 853- 6820	1j, 1m, LL, 2a
CUMBERLAND VALLEY DISTRICT HEALTH DEPARTMENT	301 CHERA-LYN LN	LONDON	KY	40743	(606) 864- 3776	1a, 1e, LL, 2e, 2g, 2k, 2L, 2p
DAVISS COUNTY HEALTH CENTER/GREEN RIVER DISTRICT HEALTH DEPARTMENT	1600 BRECKENRIDGE	OWENSBORO	KY	42303	(270) 686- 7747	1a, 1e, LL, 2e, 2g, 2k, 2L, 2p, 2h
EPISCOPAL DIOCESE AIDS MINISTRY	PO BOX 616	LEXINGTON	KY	40588	(859) 252- 6527	2K, 2J, 2L
FAMILY AND CHILDREN'S PLACE	2303 RIVER RD, 2ND FLOOR	LOUISVILLE	KY	40206	(502) 893- 3900	2k
FRANKLIN COUNTY HEALTH DEPARTMENT	100 GLENNS CREEK RD	FRANKFORT	KY	40601	(502) 564- 4269	1a, 1e, LL, 2e, 2g, 2k, 2L, 2p, 2h
FRIEND TO FRIEND	850 BARRET AVE STE 305B	LOUISVILLE	KY	40204	(502) 574- 8248	2k
HAZARD PERRY COUNTY COMMUNITY MINISTRIES HOPE CENTER	151 MISS EDNA LANE	HAZARD	KY	41701	(606) 436- 0051	2K, 2J, 2L
	PO BOX 6	LEXINGTON	KY	40588		2f, 1e, 2e, 2g, 2k, 2d
HOUSE OF RUTH	607 EAST SAINT CATHERINE ST	LOUISVILLE	KY	40203	(502) 587- 5080	2a, 2b, 2d, 2j, 2k, 2L
INFECTIOUS DISEASE CONSULTANTS	20 MEDICAL VILLAGE DR	EDGEWOOD	KY	41017	(859) 331- 1512	1a, 1k, LL, 1L
KENTUCKY ADULT AND CHILD HEALTH IMPROVEMENT DIVISION	275 EAST MAIN ST HS2WA	FRANKFORT	KY	40621	(502) 564- 4830	1a, 2L, 2a,
KENTUCKY AIDS EDUCATION AND TRAINING CENTER	800 ROSE STREET CHANDLER MED CENTER RM MN 672	LEXINGTON	KY	40536	(859) 323- 9969	2e
KENTUCKY ASSOCIATION OF SEXUAL ASSAULT PROGRAMS, INC	PO BOX 4028	FRANKFORT	KY	40604	(502) 226- 2704	2j, 2k, 2L, 1j

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KENTUCKY COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS	982 EASTERN PKWY	LOUISVILLE	KY	40217	(502) 595-4459	1e, 1h, 1j, LL, 2i, 2K, 2L, 2m, 2n
KENTUCKY DEPARTMENT OF CORRECTIONS	PO BOX 2400	FRANKFORT	KY	40602	(502) 564-2220	1a, 1m, LL, 2a, 2e, 2g, 2k, 2L, 2m, 2o, 2p, 2h
KENTUCKY DEPARTMENT OF EDUCATION (KDE)	2545 LAWRENCEBURG RD	FRANKFORT	KY	40601	(502) 564-2706	2e, 2h
KENTUCKY DEPARTMENT OF PUBLIC ADVOCACY	100 FAIR OAKS STE 302	FRANKFORT	KY	40601	(502) 564-2967	2g, 2h
KENTUCKY DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE	100 FAIR OAKS LN 4E-D	FRANKFORT	KY	40621	(502) 564-4456	1j, 2k, 2L, 2o
KENTUCKY HEALTHCARE ACCESS BRANCH	275 EAST MAIN STREET HS2EB	FRANKFORT	KY	40621	(502) 564-8966	2L
KENTUCKY HOUSING CORPORATION	1231 LOUISVILLE ROAD	FRANKFORT	KY	40601	(502) 564-7630	2f
KENTUCKY INFECTIOUS/COMMUNICABLE DISEASE BRANCH	275 EAST MAIN STREET HS2EB	FRANKFORT	KY	40621	(502) 564-3261	1a, 1k, LL, 2L
KENTUCKY MATERNAL AND CHILD HEALTH	275 EAST MAIN ST	FRANKFORT	KY	40621	(502) 564-2154	2L, 2e2f, 2g, LL, 2a, 1e
KENTUCKY STATE REFORMATORY	KSR 3001 W HIGHWAY 146	LAGRANGE	KY	40032	(502) 222-9442	1a, 1m, LL, 2a, 2e, 2h, 2g, 2k, 2L, 2m, 2o, 2p
KENTUCKY STD PROGRAM	275 EAST MAIN ST HS2CC	FRANKFORT	KY	40621	(502) 564-4804	1e,
KENTUCKY TELECARE K128 KY CKINIC	740 S. LIMESTOME	LEXINGTON	KY	40536-0284	(859) 257-6404	1a, LL, 2a, 2L
KENTUCKY VIRAL HEPATITIS	275 EAST MAIN STREET HS2EB	FRANKFORT	KY	40621	(502) 564-3261	2L
KHPAC	275 EAST MAIN HS2E-C	FRANKFORT	KY	40621	(502) 564-6539	Advisory

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LEXINGTON - FAYETTE COUNTY DETENTION CENTER	600 OLD FRANKFORT CIRCLE	LEXINGTON	KY	40510	(859) 425- 2700	1a, 1m, 2a, 2e, 2g, 2k, 2L, 2m, 2o, 2p, LL, 2h
LEXINGTON FAYETTE COUNTY HEALTH DEPARTMENT	650 NEWTOWN PIKE	LEXINGTON	KY	40508	(859) 252- 2371	1a, 2L, 2e, LL
LOUISVILLE DEPARTMENT FOR PUBLIC HEALTH AND WELLNESS	850 BARRET AVENUE, SUITE # 301	LOUISVILLE	KY	40204	(502) 574- 5600	1a, 2L, 2e, LL
LOUISVILLE METRO SECURE YOUTH DETENTION PROGRAM	700 WEST JEFFERSON ST	LOUISVILLE	KY	40202	(502) 574- 6177	1a, 1m, 2a, 2e, 2g, 2k, 2L, 2m, 2o, 2p, LL, 2h
MEDICAID SERVICES	275 EAST MAIN ST	FRANKFORT	KY	40621	(502) 564- 4321	2L
METROPOLITAN COMMUNITY CHURCH (EPISCOPAL)	1432 HIGHLAND AVE	LOUISVILLE	KY	40204	(502) 587- 6225	2j, 2k
MOVEABLE FEAST (MFL)	P O BOX 367	LEXINGTON	KY	40588	(859) 252- 2867	2d
NORTHERN KENTUCKY INDEPENDENT DISTRICT HEALTH DEPARTMENT	2388 GRANDVIEW DRIVE, BUILDING A	FORT MITCHELL	KY	41047	(859) 578- 7660	1A, LL
OWENSBORO AREA HIV/AIDS TASK FORCE, INC	224 SOUTH EWING RD	OWENSBORO	KY	42301	(270) 683- 6018	2j, 2k
PRIMARY CARE ASSOCIATION	226 WEST MAIN ST	FRANKFORT	KY	40601	(502) 227- 4379	2L
PURCHASE DISTRICT HEALTH DEPARTMENT	320 NORTH 7TH STREET	MAYFIELD	KY	42066	(270) 247- 1490	1a, LL
SISTERS AND BROTHERS SURVIVING AIDS (SABSA)	PO BOX 505	LOUISVILLE	KY	40201	(502) 231- 3871	2j, 2k
STOP AIDS	220 FINDLAY ST	CINCINNATI	OH	45202	(513) 421- 2437	2j
THE SALVATION ARMY OF CENTRAL KENTUCKY	736 WEST MAIN ST	LEXINGTON	KY	40508	(859) 252- 7706	2j
TRI STATE INFECTIOUS DISEASE	2301 LEXINGTON AVE STE 125	ASHLAND	KY	41101	(606) 325- 2721	1a
UNIVERSITY OF CINCINNATI HOSPITAL, HOLMES CLINIC	234 GOODMAN ST	CINCINNATI	OH	45219	(513) 584- 4457	1a, LL

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UNIVERSITY OF CINCINNATI INFECTIOUS DISEASES CENTER	EDEN AND BETHESDA AVES	CINCINNATI	OH	45267	(513) 558- 6977	1a, LL
UNIVERSITY OF KENTUCKY CENTER FOR RURAL HEALTH	750 MORTON BLVD	HAZARD	KY	41701	(606) 439- 3557	2L
UNIVERSITY OF KENTUCKY OFFICE OF MULTICULTURAL STUDENT AFFAIRS	563 PATTERN OFFICE TOWER	LEXINGTON	KY	40506	(859) 257- 1991	2j
UNIVERSITY OF KENTUCKY- DEPARTMENT FOR HEALTH BEHAVIOR	121 WASHINGTON AVE STE 111	LEXINGTON	KY	40536	(859) 257- 5678	1j, 2L, LL
UNIVERSITY OF LOUISVILLE DENTAL PARTNERSHIP PROGRAM	UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY RM E-2	LOUISVILLE	KY	40292	(502) 852- 2474	1d, LL
UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY (Part F Program)	501 S. PRESTON	LOUISVILLE	KY	40202	(502) 852- 5096	1d, LL
VERTERANS HOSPITAL	3200 VINE ST	CINCINNATI	OH	45220	(513) 475- 6599	1a, 1e, 1k, 2k, 2m, LL, 2h
VETERANS ADMINISTRATION	1101 VETERANS DRIVE	LEXINGTON	KY	40502	(502) 287- 5371	1a, 1e, 1k, 2k, 2m, LL, 2h
VETERANS ADMINISTRATION	800 ZORN AVE	LOUISVILLE	KY	40206	(502) 287- 4074	1a, 1e, 1k, 2k, 2m, LL, 2h
WINGS CLINIC	550 SOUTH JACKSON ST 2ND FLOOR ACB	LOUISVILLE	KY	40202	(502) 561- 8844	1a

## 2009 Kentucky Statewide Comprehensive Plan

### 7. Profile of the Ryan White Program funded providers by service category

#### Service Codes:

<u>Code</u>	<u>Service</u>	<u>Code</u>	<u>Service</u>	<u>Code</u>	<u>Service</u>
1a	Outpatient /Ambulatory Health Services	2a	Case Management (non-Medical)	2n	Respite Care
1b	AIDS Drug Assistance Program (ADAP) Treatments	2b	Child Care Services	2o	Substance Abuse Residential
1c	AIDS Pharmaceutical Assistance (local)	2c	Emergency Financial Assistance	2p	Treatment Adherence Counseling
1d	Oral Health Care	2d	Food Bank/Home-Delivered Meals		
1e	Early Intervention Services	2e	Health Education/Risk Reduction		
1f	Health Insurance Premium & Cost Sharing Assistance	2f	Housing Services		
1g	Home Health Care	2g	Legal Services		
1h	Home and Community-based Health Services	2h	Linguistics Services		
1i	Hospice Services	2i	Medical Transportation Services		
1j	Mental Health Services	2j	Outreach Services		
1k	Medical Nutrition Therapy	2k	Psychosocial Support Services		
1l	Medical Case Management (including Treatment Adherence)	2l	Referral for Health Care/Supportive Services		
1m	Substance Abuse Services--outpatient	2m	Rehabilitation Services		

#### Ryan White Funded Providers: Kentucky

1. #	2. Contract Review Cert Package No.	3. Name of Contractor	4. Street Address	5. City	6. ST	7. Zip	8. Phone Number	9. EIN	10. Provides Direct Client Services  0 = NO 1 = YES	11. Service Type (Use codes found in the instructions.)
1.	N/A	Matthew 25	411 Letcher Street	Henderson, Ky	KY	42420	270-781-8039	61-1351672	1	2a, 1l, 1f, 2i, 2d, 1j, 1a, 1d, 2c, 2e, 1c, 2p

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2.	N/A	Cumberland Valley Dist Health Dept	PO Box 1269	London	KY	40743	606-864-3732	61-1013432	1	2a, 1l, 2e, 1a, 1j, 1d, 1h, 1g, 2c, 2d, 1k, LL, R, 2p, 1f, 2p
3.	N/A	Heartland CARES, Inc.	3025 Clay Street	Paducah	KY	42001	270-444-8183	31-1525402	1	2a, 1l, 1a, 2k, 2c, 2e, 2i, 2b, 2p, 1f, 1m, 2d
4.	N/A	Bluegrass Care Clinic	740 S. Limestone Suite B 265	Lexington	KY	40536-0284	859-323-1694	61-0945743	1	1a, 1l, 1f, 2a, 2i, 1c, 2k, 1k, 2e, 2p
5.	N/A	Northern Ky Dist Health Dept	2388 Grandview Drive	Ft. Mitchell	KY	41017	859-578-7660	61-1008505	1	2a, 1l, 2j, 1j, 1d, 2k, 2e, 2d, 2i, 1f, 2p
6.	N/A	Vol of America, Louisville	850 Barrett Avenue; Suite 302	Louisville	KY	40204	502-574-0161	61-0480950	1	2a, 1l, 1a, 1j, 1d, 1m, 2k, 2c, 2d, 2g, 2i, 2k, 1f, 2e, 2p
7.	N/A	University of Ky Clinic Pharmacy	740 South Limestone St J-34	Lexington	KY	40536-0284	859-257-2509	61-6001218	1	1b
8.	N/A	University of Louisville School of Dentistry			KY					1d

### 8. Barriers to Care:

The Kentucky Part B program utilizes various methods to identify barriers to HIV care needs and gaps in services. This includes the 2008 SCSN, needs assessments, community and provider input, and client surveys. Below are the processes used to develop the current 2009 Comprehensive Plan.

**African American Needs Assessment:** In FY 2007 the state HIV/AIDS Branch through a cooperative between the National Alliance of State and Territorial AIDS Directors (NASTAD) and the federal Office of Minority Health (OMH), conducted a statewide African American Needs Assessment.

Three regional consumer focus groups were convened from July 26 to August 1, 2007. The focus groups were designed to gather information on the challenges faced by African Americans regarding access to HIV prevention and care services. NASTAD staff in collaboration with the Kentucky Department for Public Health also developed a “Kentucky Participant

## 2009 Kentucky Statewide Comprehensive Plan

Questionnaire/Demographic Instrument”, in order to capture additional information regarding needs and barriers to care for African American Kentuckians.

Focus groups were conducted in the following Kentucky cities: Louisville, Ft. Mitchell, and Paducah. These cities represented areas in the state with a disproportionately high HIV/AIDS incidence. There were a total of 19 participants (n=8 females, n=10 males and n=1 transgender-identified) in the focus groups. Although the majority of participants (n=18) self-identified as African American or Black, one participant identified as multi-racial.

### **Consumer Findings (NASTAD Needs Assessment: African Americans)**

Major themes that emerged through the analysis of consumer focus group data were based on the four major question areas asked and concentrated into the following four areas: case management and social services, medical care treatment and care settings, stigma and status disclosure, and mental health and personal beliefs.

1. Case Management and social services

Participants indicated that case managers (care coordinators) play an advocacy role for clients, and more care coordinators are needed. The care coordinators also need to improve attitudes towards clients and improve follow through. Some care coordinators need to be more interactive with African American clients and should discuss where and what services are available to the newly diagnosed.

2. Medical treatment and care settings

Many participants stated that they receive good care from all medical staff. Clinic staff addressed most care needs and pharmacists were instrumental in client care, medication and treatment adherence. Participants did have concerns regarding confidentiality among clinic and support staff, which can be a barrier to care, especially in rural areas whose clients may feel their confidentiality is safeguarded. Length of wait times for appointments and limited staff make it difficult for clients to access and stay in care. Participants suggested that more medical and social services be included at the same clinic location i.e. more “one-stop-shops” and that staff size be increased.

3. Stigma and status disclosure

The majority of participants identified reticence disclosing their HIV status due to stigma and discrimination from family, friends, neighbors, and employers. Participants also reported experiencing stigma and discrimination at social service agencies, in seeking and securing housing, and with dental care. Participants indicated that educating the community and care staff was the only way to decrease stigma.

4. Mental health and personal beliefs

Post diagnosis, many participants identified concerns of mental and emotional health. Some had come to a point of acceptance, while others were still struggling with the reality of their status. Participants expressed that going to support groups and meeting HIV positive advocates was a great source of support.

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### **a. Kentucky Statewide Coordinated Statement of Need (SCSN)**

In December of 2008, an SCSN process was completed utilizing several workgroups. Each workgroup was comprised of members with specific subject matter expertise and experience. The 2008 Kentucky SCSN included participation from PLWHA and other stakeholders from the continuum of care provider community. Several assessments and other available literature were collected and included as reference documents for the process. The completed 2008 SCSN report identified many barriers and service gaps, including the following gaps to be addressed:

1. Transportation (roundtrip) funding- Needed to transport clients for medical and case management appointments,
2. HIV related training and education for Oral Health providers
3. Retention of HIV/AIDS Clients in health care systems
4. Medication Adherence

### **2007 Kentucky Statewide Needs Assessment**

In 2007, the Kentucky Part B grantee office completed a statewide needs assessment. Clients and medical providers attended a series of focus group discussions at the Lexington Public Library. The facilitated discussions centered on HIV/AIDS care service provision issues and HIV/AIDS disease prevention. The resulting Ryan White Part B comments centered on the following concerns:

5. Kentucky should consider “one stop shops” for client care
6. Increased Funding is needed for client services
7. Increased KHCCP staff levels are needed
8. Access to medications for co-morbidities is needed
9. Expanded access to oral health services is needed
10. Increased access to Part B medical transportation services is needed.

### **c. Client Surveys**

The Kentucky Part B program distributes client surveys to all active Part B clients in the state. The average return rate for the survey is approximately 55%. These surveys provide the Part B program with vital program information that assist in decreasing the number of barriers to care and needs and gaps in services.

### d. **Part B Program Monitoring (Case Management)**

The KHCCP Administrator conducts regional Part B case management site visits every three (3) months. These quarterly site visits require the KHCCP administrator to review confidential client files and other systemic processes for tracking case management and program utilization. In addition to site visits, the KHCCP Administrator performs annual site audits to all contracted agencies which are a more detailed version of the quarterly site visit. Quarterly site visits assist in identifying barriers to care and needs and gaps in services and is used to develop strategies to increase the quality of continuum of care.

Part B case management site visits and annual audits are designed to monitor the criteria needed for each client to be eligible for Part B services and ensure client utilization of services.

In addition to the site visits and audits, each regional Part B contractor is required to submit quarterly client utilization reports to the Part B grantee office. The quarterly reports are used to monitor data regarding modes of disease exposure, gender, race/ethnicity, behavioral risk factors, enrollment trends, and other related information.

Regional contractors are also required to submit an annual quality management/assurance report to the KHCCP Administrator. This report provides specific and measurable outcomes related to program activities and quality management. The report allows regions to assess their success and identify areas for improvement. Specific emphasis in the report details activities related to access to core medical services. The annual quality management/assurance report is based on HRSA's six (6) quality management themes below:

#### **QUALITY MANAGEMENT: CENTRAL TO ADDRESSING CARE ACT THEMES**

- Providing improved access to/retention in care for HIV-positive individuals aware of their status
- Enhancing the quality of services and client outcomes
- Linking social support services to medical services
- Making program changes to respond to the evolving epidemic
- Using epidemiologic, quality, and outcomes data for planning and priority setting, and

## 2009 Kentucky Statewide Comprehensive Plan

- Ensuring accountability.

e. **Part B Program Monitoring (Fiscal Monitoring)**

The Grant Administrator conducts annual on-site fiscal monitoring visits. In addition, agencies are required to submit monthly electronic utilization reports to the Part B grantee office. Also, regular electronic and phone information is exchanged with relevant parties as issues arise.

f. **Part B Quality Management Committee**

In the fall of 2007, Kentucky formed a Quality Management (QM) committee. This committee is comprised of Part B case managers representing each contracted agency in Kentucky. The Kentucky HIV/AIDS Care Coordinator Program (KHCCP) Administrator is the Chairperson of the committee. The KADAP Administrator serves as the liaison regarding pharmaceutical matters, and there is a clinical nurse who provides updates consistent with Public health Service guidelines. The purpose of this committee is to assess and monitor current QM activities, and to establish a clinical quality management (CQM) program whose overall mission is to identify needs and gaps in the delivery of services to HIV positive individuals and ensure the statewide delivery of quality services. The Quality Management committee began meeting on a monthly basis in January, 2008. Through monthly meetings, Kentucky looked at areas that needed improvements within the Part B program and developed the 2009 Kentucky Quality Management Plan. The plan design provides a systematic process for continuous planning, designing, measuring, assessing, and improving performance.

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## SECTION II. Where Do We Need To Go

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### 1.Continuum of Care for High Quality Core Services

(a.) **Shared Vision:**

The intent of the Kentucky Ryan White Part B program is to ensure equitable access to comprehensive core services, quality health care, medications, and supportive services for Kentucky residents living with HIV/AIDS.

## **2009 Kentucky Statewide Comprehensive Plan**

### **(b.) The operational definition of continuum of care and core services:**

The Kentucky HIV/AIDS Care Coordinator Program (KHCCP) facilitates the provision of quality care and services to PLWH/A in a timely manner that is consistent across a continuum of care. The optimum goal is to provide PLWH/A the tools to become self-sufficient. Eligible individuals can access services through one of the six KHCCP regions.

### **(c.) Guiding Principles that shape the HIV-related system of care in Kentucky:**

Client and provider surveys, the SCSN, HIV needs assessments, cost effectiveness, collaborations with other entities, the Quality Management Committee, the KHCCP Manual, the Kentucky HIV/AIDS Planning and Advisory Committee (KHPAC), and HRSA Best Practices are the guiding principles that continue to shape the KHCCP. The overarching goal of the Part B program is to facilitate the provision of quality care and treatment services, empower clients and maximize opportunities for them to become self-sufficient. By fostering connections between formal and informal support systems, the program works to prevent duplication of services and to ensure that all clients have access to a holistic and comprehensive system of care.

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**SECTION III. How Will Kentucky Get There**

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**1. Performance Measures, Goals, Objectives and Strategies:**

The Comprehensive Plan is a roadmap to guide Kentucky's Part B program with performance measures, goals, objectives and effective strategies to address the barriers to care needs and gaps in services that have been identified. The priority challenges identified for the Comprehensive Plan are broken down into the following categories:

1. Kentucky AIDS Drug Assistance Program (KADAP)
2. Correctional Initiatives: HIV education, testing and linkage to care and treatment services
3. Discharge Planning
4. Transportation
5. Collaborations (Internal DPH Collaborations and the Departments of Medicaid and Medicare Services)
6. Cultural Competency
7. Provider Education
8. Oral Health
9. Quality Management
10. Disenfranchised Group (Mental Health, Substance Abuse, Homelessness, African Americans, Hispanics)
11. Part B Training and Orientation
12. HIV Prevention

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. How Will Kentucky Get There

#### KADAP Short Term Goal

### SECTION III. 2009 Comprehensive Plan

#### KADAP

#### Long-Term Goal (Medication Adherence)

#### KADAP 1 of 25 Total Goals:

Part B-ADAP Services: The Kentucky AIDS Drug Assistance Program will develop and implement an educational tool guide for clients to address medication adherence.

Measurement	Action Item	Staff	Goal/s
1. By December 31, 2009, 100% of all case managers will have an educational client specific adherence tool guide to present to all new and non-adherent current clients enrolled in the KHCCP, beginning January 1, 2010.	1. KADAP staff will work in conjunction with adherence specialists to develop the tool guide in accordance with PHS guidelines.	1. KADAP staff	1. Educate and provide case managers with the tools to counsel all clients on medication adherence. In addition, non-adherent current clients will be provided adherence education via the developed tool.

## 2009 Kentucky Statewide Comprehensive Plan

(Medication Adherence Cont.)			
<b>KADAP 2 of 25 Total Goals:</b>  Part B-ADAP Services: The Kentucky AIDS Drug Assistance Program will develop and implement a revised policy regarding KADAP client adherence to antiretrovirals.			
Measurement	Action Item	Staff	Goal/s
By March 1, 2009, 100% of all case managers and medical providers will receive a revised policy regarding adherence to KADAP formulary medications.	KADAP staff will work in conjunction with adherence specialists, medical providers and KHCCP supervisors to revise the policy.	1. KADAP staff	1. Revise adherence policy to reflect medical provider role in increasing client adherence to antiretrovirals and medication suspension.

## 2009 Kentucky Statewide Comprehensive Plan

### Discharge Planning

SECTION III. How Will Kentucky Get There			
Correctional Initiatives			
Short and Long -Term Goals			
<b>Correctional Initiatives: 3 of 25 Total Goals:</b> Part B & Prevention Services: The Kentucky Part B Program will collaborate with the HIV prevention program, the STD & TB programs, and the Department of Corrections to develop and implement a targeted HIV education, testing & linkage to care services pilot project during the initial intake process of inmates at the LaGrange correctional facility (responsible for intake processing for all state male inmates and is the medical facility housing the largest number of HIV+ inmates). Also, a refresher HIV education course and targeted testing to inmates with the highest HIV risk factors will be provided during their stay at this location.			
Performance Measure	Do	Responsible Program/Person	Goals
1. By December 31, 2009 the Part B grantee staff in collaboration with the HIV prevention program, the STD & TB programs, and the Department of Corrections will complete 100% of the design & development of the pilot project 2. By December 31, 2010, a 100% of incoming inmates	1. Request TA through the CDC CRIS system for subject matter expert to guide corrections initiative efforts & provide training. 2. HIV prevention and care staff to research and collect sample projects from other states. 3. Compile a resource inventory of relevant	1. Part B grantee and HIV prevention staff. 2. HIV/AIDS and Communicable Disease Branches 3. KY Department	1. Reduce the burden of unmet need by identifying incarcerated PLWHA and linking them to care and treatment services. 2. Provide basic HIV education, risk reduction and behavior change skills to inmates at high risk for HIV infection. 3. Link HIV+ exiting inmates to care and treatment services. 4. Reduce the HIV transmission rates among inmates and from inmates to the general population.

## 2009 Kentucky Statewide Comprehensive Plan

<p>identified as “at-high-risk for HIV infection” will be provided with HIV education, testing &amp; linkage to care services during the initial intake process.</p> <p>3. By December 2011, commence providing to a 100% of inmates at high risk for HIV infection, incident based testing, continuing peer education, group behavioral change interventions, and linkage to treatment and care while housed at LaGrange.</p>	<p>resources and partner/referral agencies.</p> <p>4. Convene task force of relevant stakeholders to identify and outline action steps and project activities.</p> <p>5. Design pilot project components (education program, testing project, peer based initiative, behavioral change intervention, linkage to treatment and care services).</p> <p>6. Conduct cost analysis and identify key personnel to staff project.</p> <p>7. Commence initial project activities in 2010.</p>	<p>of Corrections</p>	<p>5. Enhance collaboration activities between organizations providing services that are relevant to incarcerated persons and exiting inmates.</p> <p>6. Develop an inmate specific and comprehensive resource inventory list.</p> <p>7. Gather data and information to support future statewide expansion of the project.</p>
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## 2009 Kentucky Statewide Comprehensive Plan

### Discharge Planning

SECTION III. How Will Kentucky Get There			
Direct Services/KHCCP			
Long term Goal			
(Discharge Planning)			
<b>Discharge Planning: 4 of 25 Total Goals:</b>			
Develop and Implement a Discharge Planning Pilot Program at LaGrange State Correctional Facility, which houses the largest number of HIV+ Inmates in Kentucky.			
Measurement	Action Item	Staff	Goal/s
1. By December 31, 2009, the Kentucky Part B Program will develop and implement a Discharge Planning pilot program at LaGrange Correctional Facility.	1. Part B staff, relevant KHCCP contractors, relevant medical staff at LaGrange, Correctional Advisory Task Force will outline and implement plan activities. 2. Monthly review of plan and activities.	1. Part B staff, relevant LaGrange medical staff.	1. Ensure HIV+ inmates are referred to needed services. 2. Reduce HIV infection rates from inmates to the general population. 3. Improve retention in care for HIV+ released inmates.
2. 75% of HIV+ inmates being release from LaGrange Correctional Facility will receive Discharge Planning services by June, 2010	1. Part B staff, relevant KHCCP contractors, relevant medical staff at LaGrange, Correctional Advisory Task Force will outline, implement and oversee plan activities. 2. Monthly review of plan and activities.	1. Part B staff, relevant LaGrange medical staff.	4. Ensure HIV+ inmates are referred to needed services. 5. Reduce HIV infection rates from inmates to the general population. 6. Improve retention in care for HIV+ released inmates, which will help reduce the burden of unmet need. 7. Gather data to support future expansion of program

## 2009 Kentucky Statewide Comprehensive Plan

### Transportation

SECTION III. How Will Kentucky Get There			
Direct Services/KHCCP			
Short-Term Goal			
(Transportation)			
<b>Transportation: Goal 5 of 25 Total Goals:</b>			
<b>The Part B Program Will Enhance Transportation Opportunities and Develop Cost Saving Strategies for Medical and Case Management Appointments for Clients in the Eastern Region of the State.</b>			
Measurement	Action Item	Staff	Goal/s
1. The Part B program located in the eastern region will provide van and/or carpooling services to 80% of clients with transportation challenges by December 31, 2009.	1. The Part B case managers in the Eastern Part B program will develop a volunteer system to provide transportation to clients for medical and case management appointments.  2. Part B staff will assist the Eastern region in identifying strategies for transportation opportunities that will provide cost saving transportation needs to clients.	1. Part B staff. 2. Case managers in the Eastern region.	1. Implement cost saving strategies that provide necessary transportation opportunities for clients.  2. Improve retention in care and treatment services.  3. Improve timely enrollment and access to care and treatment services

## 2009 Kentucky Statewide Comprehensive Plan

### Collaborations

Collaborations Short -Term Goal (Internal DPH programs)			
<b>Collaborations: Goal 6 of 25 Total Goals:</b> Part B & Prevention Services: Convene an internal Department for Public Health (DPH) task force of relevant staff from the HIV branch, STI program, TB program, Immunization program, Hepatitis program, Maternal and Child Health branch, and the Office of Health Equity to identify areas collaboration.			
Performance Measure	Do	Responsible Program/Person	Goals
1. By December 31, 2009 the HIV/AIDS program will collaborate with the identified DPH programs to convene a task force responsible for identifying a minimum of 4 initiatives to collaborate on.	1. Conduct an initial meeting with key identified staff from each program, to discuss task force proposal. Identify additional staff relevant to the initiative and invite them to the next meeting. 2. Identify and prioritize joint initiative opportunities. 3. Outline collaborative processes for 100% of all the top prioritized initiatives. 4. Incorporate outlined processes into the operating procedures and policies of the applicable programs.	1. Identified programs within the Department for Public Health	1. Enhance collaboration activities between DPH programs. 2. Reduce service duplication, maximize resources, and increase program effectiveness. Amplify service reach and impact. Increase community access to applicable DPH services.

## 2009 Kentucky Statewide Comprehensive Plan

### Collaborations

SECTION III. How Will Kentucky Get There			
Collaborations			
Short-Term Goal			
(Data Sharing)			
<b>Collaborations 7 of 25 Total Goals:</b>			
Part B Services: The Kentucky Part B Program will implement measures to facilitate data exchange between the HIV/AIDS Program and the Department of Medicaid and Medicare.			
Measurement	Action Item	Staff	Goal/s
1. By February 1, 2009, 100% of the data exchange “test phase” with Medicare will be completed.	1. KADAP staff will work with the Medicare Coordination of Benefits representative to complete the test phase.	1. KADAP staff and Medicare’s designated Coordination of Benefits representative(s).	1. Implement data exchange process with Medicare to identify an alternate payer source of medications for the treatment of HIV/AIDS.
2. By March 1, 2009, 80% of the data exchange process with the Department of Medicaid will be completed.	2. KADAP staff will work with Surveillance staff and appointed Medicaid staff to complete the data exchange process.	2. KADAP and Surveillance staff and Department of Medicaid representative(s).	2. Implement a Memorandum of Understanding between the HIV/AIDS Branch and the Department of Medicaid to facilitate data exchange. Data will identify KADAP clients with an alternate payer source and assist Surveillance with estimation of unmet need.  3. Facilitate relevant information exchange and input on policy and procedures in an effort to improve provision of quality services to PLWHA

## 2009 Kentucky Statewide Comprehensive Plan

### Part B Training

SECTION III. How Will Kentucky Get There			
Direct Services/KHCCP			
Short-Term Goal			
(Part B Training)			
<b>Mental Health 8 of 25 Total Goals:</b>			
The Kentucky Part B Program Will Increase Opportunities for Education, Training, and Professional Development for Case Managers on Mental Health and Substance Abuse.			
Measurement	Action Item	Staff	Goal/s
1.100% of the Part B staff will receive training on substance abuse and mental health issues and at least 10% will complete clinical preceptorships by December, 31, 2009	1. Incorporate substance abuse and mental health sessions in the 2009 HIV/AIDS Conference.  2. Develop a preceptorship program at local agencies providing substance abuse and mental health treatment services.	1. Part B Staff.  2. KY AIDS Education & Training Center.	1. Educate Part B Case Managers and arrange for clinical preceptorships relevant to mental health and substance abuse issues in caring for patients living with HIV/AIDS. 2. Expand and enhance assessment of and service provision to PLWHA with substance abuse and mental health needs

## 2009 Kentucky Statewide Comprehensive Plan

### Part B Staff Cultural Competency

#### SECTION III. 2009 Comprehensive Plan

#### Short-Term Goal

#### (Part B Staff Cultural Competency)

#### Cultural Competency 9 of 25 Total Goals:

The Kentucky Part B Program will provide cultural competency training as well as conduct activities to improve and enhance links and services to African American Communities

Measurement	Action Item	Staff	Goal/s
<p>1. By December, 2009 the Part B staff will offer 2 workshops on cultural competency to participants at two annual HIV conferences.</p> <p>2. By December, 31 2009, Part B staff will collaborate with churches and various organizations within the African community to provide a total of 4 HIV 101 trainings.</p> <p>3. By December 31, 2010 the HIV/AIDS Branch staff will contact 100% of identified agencies to provide HIV education and enhanced linkages to testing, care and treatment services.</p>	<p>1. Provide cultural competency sessions at the 2009 HIV/AIDS Conference and 2009 African American and Hispanic Leadership conference.</p> <p>2. Conduct an assessment of indigenous African American (such as the Black Church Coalition, BUILD, and the Urban Leagues of Lexington /Louisville, and the NAACP) organizations in areas of high HIV prevalence and implement collaborative initiatives</p>	<p>1. The Part B staff.</p> <p>2. KY AIDS Education &amp; Training Center.</p>	<p>1. Improve cultural competency of statewide providers.</p> <p>2. Reduce stigma and increase awareness within African American communities and churches.</p> <p>3. Educate the African American community on the prevention and spread of HIV/AIDS.</p> <p>4. Provide timely identification of HIV infected African Americans</p> <p>5. Enhance and expand linkage to care services for HIV infected African Americans</p>

## 2009 Kentucky Statewide Comprehensive Plan

### Provider Education

SECTION III. How Will Kentucky Get There			
Short-Term Goal			
(Provider Education)			
Provider Education 10 of 25 Total Goals:			
The Kentucky HIV/AIDS Branch Will Provide HIV 101 Trainings to Providers in the State.			
Measurement	Action Item	Staff	Goal/s
1. The Kentucky HIV/AIDS Branch will conduct four (4) HIV 101 trainings to medical providers in the Western and Eastern parts of the state by December 31, 2009.	1. The HIV/AIDS Branch's Continuing Education Program Administrator will identify applicable providers and target them for trainings.	1 .The HIV/AIDS Branch's <b>Continuing Education Program Administrator</b>  2. Part B staff.	1. Increase the level of HIV competency for medical providers in the Western and Eastern parts of the state. 2. Reduce provider stigma & prejudice in rural areas of the state 3. Improve early identification of and service provision to rural PLWHA

## 2009 Kentucky Statewide Comprehensive Plan

### Provider Training

SECTION III. How Will Kentucky Get There			
Short-Term Goal			
(Oral Health-Provider Training)			
Provider Training: Oral Health 11 of 25 Total Goals:			
Oral Health issues: The Kentucky HIV/AIDS Branch Will facilitate HIV 101 Trainings to Dentists in selected rural areas in the State			
Measurement	Action Item	Staff	Goal/s
1. The Kentucky HIV/AIDS Branch will collaborate with the Part F staff to develop and conduct four (4) HIV trainings for dentists within the state by December 31, 2009.	1. The HIV/AIDS Branch's Continuing Education Program Administrator will identify applicable dentists and target them for trainings that focus on the oral manifestations of HIV and the oral health needs of PLWHA	<b>1.</b> The HIV/AIDS Branch's Continuing Education Program Administrator <ul style="list-style-type: none"> <li>1. Part B staff.</li> <li>Part F staff</li> </ul>	<ul style="list-style-type: none"> <li>1. Increase the level of HIV competency for dentists in the rural areas of the state.</li> <li>2. Increase the multi-disciplinary collaborations related to HIV care and services.</li> <li>3. Improve the provision of quality oral health services to PLWHA</li> </ul>

## 2009 Kentucky Statewide Comprehensive Plan

### Oral Health

SECTION III. How Will Kentucky Get There			
Long-Term Goal			
(Oral Health- Part C Provider Education)			
Oral Health 12 of 25 Total Goals:			
Part C clinicians will receive specialized training regarding oral health issues in the HIV/AIDS community			
Measurement	Action Item	Staff	Goal/s
By Dec 31, 2010 100% of all Part C Clinicians will have received specialized training regarding oral health issues in the HIV/AIDS patient community.	1. Collaborate with Part F and AETC staff to develop training on the oral manifestations of HIV  Conduct specialized trainings regarding the oral health needs of the HIV/AIDS client community.	Kentucky AIDS Education Training Center (AETC), Kentucky Part F (Dental) staff and Part B grantee staff will assist in facilitating this process.	1. Facilitate the timely assessment and recognition of oral diseases in PLWHA and increase referrals to oral health care.  2. Improve the provision of quality oral health services to PLWHA  Improve the oral health competency of Part C providers

### Oral Health

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan

#### Short-Term Goal

#### (Oral Health-Provider Training)

#### Oral Health 13 of 25 Total Goals:

The Kentucky HIV/AIDS Branch Will Provide Oral Health Assessments for Clinicians Treating HIV Positive Persons.

Measurement	Action Item	Staff	Goal/s
1. The Kentucky HIV/AIDS Branch will provide oral health workshops to medical care providers, by May, 2009.	1. Include a session on oral manifestations of HIV in the 2009 HIV/AIDS Conference.	1. Part B Staff.  2. University of Louisville College of Dentistry.  3. KY AIDS Education & Training Center (AETC).	1. Increase the level of HIV competency for dentists in the rural areas of the state.  1. Increase the multi-disciplinary collaborations related to HIV care and services. 2. Increase the level of oral health competency of service providers

## Quality Management

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan

#### Long-Term Goal

#### (Quality Management)

#### Quality Management 14 of 25 Total Goals:

The Kentucky HIV/AIDS Branch Will Provide Technical Assistance on Quality Improvement Measures for Medical Care Providers.

Measurement	Action Item	Staff	Goal/s
<p>1. The Part B staff will coordinate CQI training for 100% of the infectious disease (ID) providers attending the annual conference by May, 2010.</p> <p>2. By December 2009, Part B staff will collaborate with AETC to include CQI sessions within the monthly teleconference and webinar training of medical providers</p>	<p>1. Part B Staff will identify all ID providers that regularly attend the annual HIV/AIDS Conference and invite them to the training.</p> <p>2. Part B staff will coordinate the provision of activities and sessions on quality improvement measures for infectious disease providers, reducing the burden of human and financial resources.</p> <p>3. Part B staff will distribute and market best practices for treatment of co-morbidity.</p>	<p>1. Part B Staff.</p> <p>2. Program Directors on the conference committee.</p> <p>3. KY AIDS Education and Training Center.</p>	<p>1. Improve CQI competency of medical providers</p> <p>2. Enhance provision to PLWHA of quality services for the treatment of co-morbidities. .</p> <p>3. Increase provider access to best practice CQI samples.</p>

Disenfranchised populations

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan Short-Term Goal

(Hispanics)

#### Disenfranchised Populations 15 of 25 Total Goals:

Hispanics: The Kentucky Part B Program will assess the HIV Unmet Needs of areas in the state that have the largest and/or fastest growing populations of Hispanic individuals and provide education and training to the organizations and agencies that serve them; as well as facilitate linkage to prevention, testing, and care & treatment services.

Measurement	Action Item	Staff	Goal/s
<ol style="list-style-type: none"> <li>By December 31, 2009 the Part B grantee staff will conduct an assessment to identify areas which have the highest and fastest growing populations of Hispanic individuals and will make contact with CBO's and social service agencies serving these populations.</li> <li>By December 31, 2010 the HIV/AIDS Branch staff will contact 100% of identified agencies to provide HIV education and enhanced linkages to testing, care and treatment services.</li> </ol>	<ol style="list-style-type: none"> <li>Part B staff develops an assessment tool to gather unmet need data regarding Hispanic individuals</li> <li>Collaborate with the HIV Prevention Program to outline the process for enhancing linkages to testing, care and treatment services.</li> </ol>	<ol style="list-style-type: none"> <li>Part B grantee staff.</li> <li>HIV/AIDS Branch</li> </ol>	<ol style="list-style-type: none"> <li>To identify HIV unmet needs of Hispanic individuals in the largest Hispanic populated areas of the state.</li> <li>Improve linkages and retention in care for HIV+ Hispanic individuals, in order to reduce the burden of unmet need.</li> <li>Increase the HIV competency of Hispanic serving organizations in Hispanic populated regions.</li> <li>Improve early identification of Hispanic PLWHA.</li> <li>Reduce stigma and increase HIV awareness in Hispanic communities.</li> </ol>

#### Disenfranchised Populations

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan

#### Short-Term Goal

#### (Homelessness)

**Disenfranchised Populations: 16 of 25 Total Goals:**

**Homelessness: The Kentucky Part B Program will evaluate and assess the HIV Unmet Needs of homeless populations through collaborations with the major homeless shelters in the Louisville and Lexington areas; as well as provide linkage to services**

Measurement	Action Item	Staff	Goal/s
<p>1. By December 31, 2009 the Part B staff will meet with 100% of the directors of the major homeless shelters in Louisville and Lexington to begin assessment of the HIV needs within the homeless population.</p> <p>2. By December, 2010, the HIV Branch will commence provision of HIV education and enhanced linkages to testing, care and treatment services within the identified homeless centers.</p>	<p>1. Part B staff develops an assessment tool to gather unmet need data regarding homeless individuals.</p> <p>2. Homeless shelter's directors will participate in the assessment.</p>	<p>1. The Part B staff.</p>	<p>1. To identify HIV unmet needs of major homeless shelters in Louisville and Lexington.</p> <p>2. Improve linkages and retention in care for homeless HIV+ individuals, in order to reduce the burden of unmet need.</p> <p>3. Improve HIV competency of homeless shelter staff</p> <p>4. Improve early identification of homeless PLWHA</p>

## 2009 Kentucky Statewide Comprehensive Plan

### Disenfranchised Populations

<b>SECTION III. 2009 Comprehensive Plan</b> <b>Direct Services/KHCCP</b>  <b>Short-Term Goal</b> <b>(Substance Abuse)</b>			
<b>Disenfranchised Populations 17 of 25 Total Goals:</b> Substance Abuse: The Kentucky Part B Program will evaluate and assess the HIV Unmet Needs of areas in the State with the Highest Level of substance abuse, provide Education and Training to the Substance Abuse Centers in the Identified Area, and facilitate linkage to prevention, testing, and care & treatment services			
Measurement	Action Item	Staff	Goal/s
1. By December 31, 2010 the Part B staff will contact 100% of the identified substance abuse centers.  2. By December, 2011, the HIV Branch will commence provision of HIV education and enhanced linkages to testing, care and treatment services within the identified homeless centers	1. The HIV/AIDS Branch will develop an inventory of relevant providers in the regions with the highest prevalence of substance abuse.  1. Part B & HIV prevention staff will meet with staff from the identified substance abuse centers.  2. The HIV/AIDS Branch will provide education and TA. for substance abuse center staff. 3. The HIV/AIDS Branch will develop a service program to be implemented within the identified centers	1. HIV/AIDS Branch	1. Improve linkages and retention in care of substance abusers in order to reduce the burden of unmet need.  2. Improve HIV competency of substance abuse center staff  3. Improve early identification of substance abusers who are PLWHA

### Disenfranchised Populations

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan Direct Services/KHCCP

#### Short-Term Goal

#### (Mental Health)

#### Disenfranchised Populations 18 of 25 Total Goals:

Mental Health: The Kentucky Part B Program will assess the HIV Unmet Needs of the of Areas in the State with the Highest Level of Mental Health issues, provide Education and Training to the Mental Health Centers in the Identified Areas, and facilitate linkage to prevention, testing, and care & treatment services

Measurement	Action Item	Staff	Goal/s
1. By December 31, 2009 the Part B staff will do an assessment to determine what areas of the state have the highest level of mental health issues and make contact with those mental health centers.	1. Obtain and assess mental health data from the Ky Dept. for Disability Determinations, and selected state universities, other Comprehensive care centers in Ky.  2. Contact the KY Dept. for Mental Health/Mental Retardation to collect and assess mental health data.	1. The Part B staff. 2. The HIV/AIDS Branch	1. To identify the areas of the state that has the highest rate of mental health issues.  2. Improve HIV competency of mental health providers

#### Disenfranchised Populations

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan Direct Services/KHCCP

#### Short-Term Goal

#### (Mental Health)

#### Disenfranchised Populations 19 of 25 Total Goals:

Mental Health Issues: The Kentucky Part B Program Will Assess the HIV Unmet Needs of the of Areas in the State Who Have the Highest Level of Mental Health Issues and Provide Education and Training to the Mental Health Centers in the Identified Areas.

Measurement	Action Item	Staff	Goal/s
<p>1. By December 31, 2010 the Part B staff will contact 100% of the identified mental health centers.</p> <p>2. By December, 2011, the HIV Branch will commence provision of HIV education and enhanced linkages to testing, care and treatment services within the identified homeless centers</p>	<p>1. Part B staff will meet with staff from the identified mental health centers.</p> <p>2. The HIV/AIDS Branch will provide education and technical assistance (TA) for substance abuse center staff.</p> <p>3. The HIV/AIDS Branch will develop a service program to be implemented within the identified centers</p>	<p>1. HIV/AIDS Branch</p> <p>2. The State HIV Conference Committee.</p>	<p>1. Improve linkages and retention in care to substance abuse centers, which will reduce the burden of unmet need.</p> <p>2 Improve early identification of PLWHA with mental health problems</p> <p>3. Improve linkages and retention in care of PLWHA with mental health problems in order to reduce the burden of unmet need.</p> <p>4. Improve HIV competency of mental health providers</p>

#### Part B Staff Training

## 2009 Kentucky Statewide Comprehensive Plan

SECTION III. How Will Kentucky Get There			
Direct Services/KHCCP			
Long-Term Goal			
(Part B Staff Training)			
Part B Training 20 of 25 Total Goals:			
The Kentucky Part B Program will Develop and Implement a KHCCP Orientation Training Program for New Case Managers			
Measurement	Action Item	Staff	Goal/s
1.100% of the Part B staff will receive training on comprehensive cultural competency, medication adherence, substance abuse and mental health from experts in each of these fields by December 31, 2009.	1. The Part B staff. Will work with subject matter experts to develop and implement the training program.	1. The HIV/AIDS Branch designated HIV 101 trainer. Part B staff.	1. Instruction in these areas will assist Part B staff in the development of training modules that assist in the development of a Best Practices manual given to new case managers during KHCCP orientation. 2. Improve services on cultural competency, quality of medication adherence, substance abuse and mental health provided by the six regional KHCCP contractors.

### Part B New Staff Orientation

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan

#### Long-Term Goal

#### (Part B Contracted Staff Training)

**Part B Staff Orientation 21 of 25 Total Goals cont:**

#### The Kentucky Part B Program Will Develop and Implement a KHCCP Orientation Training to New Case Managers

Measurement	Action Item	Staff	Goal/s
1. By December 31, 2010, the Part B program will develop and conduct a KHCCP orientation for 100% of new case managers.	1. Part B staff will set up trainings for new case managers every six (6) months.  2. New case managers hired by each KHCCP contractor will participate in the KHCCP orientation.  3. Utilize subject matter experts for assistance with development of training tools.	1. Part B staff	1. Improve subject matter competency of all case managers.  2. Improve services on cultural competency and quality of medication adherence, substance abuse and mental health provided by the six regional KHCCP contractors.

#### Part B Staff Training

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan

#### Long-Term Goal

(Part B Contracted Staff Training cont.)

#### Part B Training 22 of 25 Total Goals

#### The Kentucky Part B Program Will Develop and Implement a KHCCP Orientation Training to New Case Managers

Measurement	Action Item	Staff	Goal/s
1. By December 31, 2009, 100% of all Part B case managers will receive annual, targeted training in the areas of comprehensive cultural competency, medication adherence, substance abuse and mental health	1. Part B staff 2. Expert subject matter individual to assist in the trainings.	1. Part B staff	1. Improve subject matter competency of all case managers. 2. Improve services on cultural competency, quality of medication adherence, substance abuse and mental health provided by the six regional KHCCP contractors.

#### HIV Prevention

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan

#### Short-Term Goal

#### HIV Prevention 23 of 25 Total Goals

**All Health Departments will have access to the state training calendar. Counseling and Testing training will be approved.**

Measurement	Action Item	Staff	Goal/s
1. By December 31, 2009, all local health departments (LHDs) will have access to the state training calendar ( <a href="http://www.Ky.TRAIN.org">www.Ky.TRAIN.org</a> ). The HIV counseling and testing (CTS) training will be approved and updated for continuing education units (CEUs)	1. The HIV Branch will send out information to the LHDs regarding how to access the CTS training calendar and register. 2. HIV Health Policy Specialist will monitor courses for updating. 3. HIV Health Policy Specialist will add new courses as they are approved. 4. HIV Health Policy Specialist will remove outdated courses.	1. The HIV Prevention Staff 2. The DPH TRAIN Administrators	1. Educate and train relevant LHD staff on CTS and provide CEUs as mandated by Kentucky statute. 2. Improve CTS proficiency of LHD staff. Enhance CTS services at LHDs across the state

## 2009 Kentucky Statewide Comprehensive Plan

### HIV Prevention

SECTION III. 2009 Comprehensive Plan			
Short-Term Goal			
HIV Prevention			
<b>HIV Prevention 24 of 25 Total Goals cont:</b>			
<b>Press Releases highlighting prevention activities will be posted four to five times a year.</b>			
Measurement	Action Item	Staff	Goal/s
1. By December 31, 2009, the HIV Prevention program will develop and post press releases highlighting prevention activities.	1. HIV Prevention Staff will post press releases on a quarterly basis.  2. HIV Prevention Staff will post press releases dealing with national testing and HIV awareness days.  3. HIV Prevention Staff will post press releases pertaining to state sponsored conferences.  4. The HIV/AIDS branch will disseminate press release via the CHFS office of communications to media outlets within Kentucky and bordering states.	1. HIV Prevention Staff 2. The Continuing Education Program Administrator	1. The HIV Prevention Program has established a link on the Department for Public Health website to add Prevention and Counseling Testing information. Press releases will be posted to educate and announce prevention activities.  2. Increase HIV awareness and reduce stigma in the general population.

### HIV Prevention

## 2009 Kentucky Statewide Comprehensive Plan

### SECTION III. 2009 Comprehensive Plan Short-Term Goal

#### HIV Prevention

**HIV Prevention 25 of 25 Total Goals cont:**

**The HIV Prevention Program will continue efforts to partner with African-American churches and indigenous organizations.**

Measurement	Action Item	Staff	Goal/s
By December 31, 2009, the HIV Prevention program will continue to develop efforts to partner with African-American churches, indigenous organizations, and educational groups.	<ol style="list-style-type: none"> <li>1. HIV Prevention Staff will develop a list of churches and target them for collaboration to address HIV issues.</li> <li>2. HIV Prevention Staff will continue to sponsor the African-American Latino Leadership Conference that includes a Faith Based Initiative.</li> <li>3. The HIV Prevention Program will offer Capacity Building Funds to non traditional partners, including churches and education groups, to host events targeting disproportionately affected populations focusing on HIV education and testing.</li> </ol>	<ol style="list-style-type: none"> <li>1. HIV Prevention Staff</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase efforts to partner with African-American churches, indigenous organizations, and educational entities to educate, address, and foster service delivery regarding HIV.</li> <li>2. Decrease HIV stigma and increase awareness within African American communities.</li> <li>3. Timely identification of African American PLWHA and improvement of linkage to care and treatment services.</li> </ol>

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**Section IV: HOW WILL WE MONITOR OUR PROGRESS**

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The Part B staff will closely monitor the short and long term goals identified in this document. Annual updates to the comprehensive plan will be conducted, and priorities will be amended as the operational and program environment dictates.

Client Level Data (CLD) will be used to evaluate and monitor quality of care, program effectiveness, performance and needed changes, as well as evaluate the progress of the long and short term goals. Client Level Data will allow the Part B program to successfully measure program outcomes based on an unduplicated number of clients served. This will allow the Part B program to have a snapshot of the client demographics, types of services being accessed, client medical care, and funding streams and determine service expansion and enhancement, particularly for goals targeting emerging populations, groups with significant unmet need and disenfranchised populations.

The Part B program will use CLD to evaluate the success of performance measures that are outlined in the Comprehensive Plan. Data analysis will provide a true assessment of the clients being served, the services being utilized, unmet needs, and appropriate funding for the HIV epidemic. Data will provide a strong basis for setting service priorities for the HIV infected individuals in the state and eliminating disparities in accessing core medical services.

Collaborations with other service providers will assist the Part B program in evaluating the progress of the Comprehensive Plan outcomes. These collaborations are also important in achieving success with long and short term program goals.

## Appendix

### Glossary

1. **AETC (AIDS Education and Training Center)** - Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the CARE Act and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).
2. **ADAP (AIDS Drug Assistance Program)** - Administered by States and authorized under Title II of the CARE Act, provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured CARE Act clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.
3. **ADD (Area Development District)** – The sixteen (16) geographic regions of Kentucky,
4. **Adherence** – The degree to which a PLWH maintains participation in prescribed medical and non-medical regimens and referrals to care services.
5. **AIDS (Acquired Immunodeficiency Syndrome)** - A disease caused by the human immunodeficiency virus.
6. **Antiretroviral** - A substance that fights against a retrovirus, such as HIV.
7. **CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)** - Federal legislation created to address the unmet health care and service needs of people living with HIV Disease (PLWH) disease and their families. It was enacted in 1990 and reauthorized in 1996 and 2000.
8. **CBO (community-based organization)** - An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.
9. **Co-morbidity** - A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.
10. **Comprehensive Planning** - The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.

## 2009 Kentucky Statewide Comprehensive Plan

11. **Community Health Centers** - Federally-funded by HRSA's Bureau of Primary Health Care, centers provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.
12. **Comprehensive Plan** – A guiding document for programmatic decisions and activities
13. **Consortium/HIV Care Consortium** - A regional or statewide planning entity established by many State grantees under Title II of the CARE Act to plan and sometimes administer Title II services. An association of health care and support service agencies serving PLWH under Title II of the CARE Act.
14. **Continuous Quality Improvement** - An ongoing process that involves organization members in monitoring and evaluating programs to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care by identifying opportunities for improvement.
15. **Continuum of Care** - An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH.
16. **Core Medical Services** - Essential medical care which includes
  - a. outpatient and ambulatory health services;
  - b. pharmaceutical assistance;
  - c. substance abuse outpatient services;
  - d. oral health;
  - e. Medical case management/Care Coordination
  - f. medical nutritional therapy;
  - g. health insurance premium assistance;
  - h. home health care;
  - i. hospice services;
  - j. mental health services;
  - k. early intervention services; and
  - l. medical case management, including treatment adherence services
17. **Cultural Competence** - The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

## 2009 Kentucky Statewide Comprehensive Plan

18. **Discharge Planning** – The promotion of best practices which will ensure the continuity of health and supportive care for PLWH who are:

(a) preparing to exit the correctional system as part of effective discharge planning; or

(b) are in the correctional system for a brief period, which would not include any type of discharge planning. 'Incarcerated person' refers to an individual involuntarily confined in association with an allegation or finding of behavior that is subject to criminal prosecution. Thus, the policy applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities. Furthermore, this includes individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential half-way house) if the individual is still involuntarily confined to those settings.

19. **Epidemic** - A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

20. **Epidemiologic Profile** - A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

21. **Epidemiology** - The branch of medical science that studies the incidence, distribution, and control of disease in a population.

22. **Exposure Category** - In describing HIV/AIDS cases, same as transmission categories; how an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.

23. **Grantee** - The recipient of CARE Act funds responsible for administering the award.

24. **Health Insurance Continuity Program (HICP)** - A program primarily under Title II of the CARE Act that makes premium payments, co-payments, deductibles, and/or risk pool payments on behalf of a client to purchase/maintain health insurance coverage.

25. **Health Resources and Services Administration [HRSA]** – The federal agency of record. This agency is responsible for the federal administration of the Ryan White program.

26. **HIV/AIDS Bureau (HAB)** - The bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White CARE Act.

27. **HIV/AIDS Dental Reimbursement Program** - The program within the HRSA HIV/AIDS Bureau's Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to PLWH.

28. **HIV Disease** - Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

## 2009 Kentucky Statewide Comprehensive Plan

29. **Incidence** - The number of new cases of a disease that occur during a specified time period.
30. **Incidence Rate** - The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.
31. **Lead Agency/Grantee Office/Central Office** - The agency within a Title II consortium that is responsible for contract administration; also called a fiscal agent.
32. **Needs Assessment** - A process of collecting information about the needs of PLWH (both those receiving care and those not in care), identifying current resources (CARE Act and other) available to meet those needs, and determining what gaps in care exist.
33. **One Stop Shop** – A location in which PLWH may receive a variety of coordinated Ryan White services, including case management and medical treatment.
34. **Opportunistic Infection (OI) or Opportunistic Condition** - An infection or cancer that occurs in persons with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus (CMV) are all examples of opportunistic infections.
35. **Part B** - The part of the CARE Act that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWH and their families.
36. **Part C** - The part of the CARE Act that supports outpatient primary medical care and early intervention services to PLWH through grants to public and private non-profit organizations. Title III also funds capacity development and planning grants to prepare programs to provide EIS services.
37. **Part D** – Services for youth, women, and children infected with HIV disease.
38. **Part F** – Programs of special significance
39. **Planning Council** - A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish priorities for the use of Title I CARE Act funds.
40. **Planning Process** - Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.
41. **PLWH (People Living with HIV Disease)**
42. **Prevalence** - The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).
43. **Prevalence Rate** - The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

## 2009 Kentucky Statewide Comprehensive Plan

44. **Priority Setting** - The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.
45. **Quality** - The degree to which a health or social service meets or exceeds established professional standards and user expectations.
46. **QA (Quality Assurance)** - The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.
47. **QI (Quality Improvement)** - Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.
48. **Representative** - Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.
49. **Risk Factor or Risk Behavior** - Behavior or other factor that places a person at risk for disease; for HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.
50. **SAMHSA (Substance Abuse and Mental Health Services Administration)** - Federal agency within HHS that administers programs in substance abuse and mental health.
51. **SCSN (Statewide Coordinated Statement of Need)** - A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN process is convened by the Title II grantee, with equal responsibility and input by all programs.
52. **Service Gaps** - All the service needs of all PLWH except for the need for primary health care for individuals who know their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care (“in care”).
53. **STD (Sexually Transmitted Disease)**
54. **Supportive Services**- Services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. The law outlines support services as:
  - a. outreach;
  - b. medical transportation;
  - c. language services;
  - d. respite care for persons caring for individuals with HIV/AIDS; and

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- e. referrals for health care and other support services

- 55. **Surveillance** - An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (*e.g.*, Centers for Disease Control and Prevention surveillance system for AIDS cases).
- 56. **TA (Technical Assistance)** - The delivery of practical program and technical support to the CARE Act community. TA is to assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act-supported planning and primary care service delivery systems.
- 57. **TB** - Tuberculosis
- 58. **Target Population** - A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.
- 59. **Transmission Category** - A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.
- 60. **Unmet Need** - The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.